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Final Project: IPH 5180

Doctorate of Professional Studies (Health)

**A Project submitted in partial fulfilment of the requirements for the
Professional Doctorate in Health**

**“An Assessment of Cultural Competence of Community Public
Health Nursing in Liffeside Health Service Area, Dublin”**

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Abstract

This study aimed to investigate the cultural competence and transcultural nursing experiences of community nurses in a local health service area in response to increasing demographic change and cultural diversity. In response to a dearth of evidence-based transcultural nursing research in the Irish context, this work-based project primarily explored practice, service delivery and professional development within an individual and localised service context. The study was informed by my own professional role as a Clinical Nurse Specialist working with asylum seekers in the Health Service Executive organisation.

A flexible research design was employed, using a mixed methodology of quantitative and qualitative methods. To determine levels of cultural competence, quantitative data was collected and analysed using a specialised cultural competence assessment tool (CCAT Survey Questionnaire) and software. A total population of 44 nurses (N=44) were surveyed in Liffeside health service area. 54.4% (n=24) completed and returned the CCAT survey. It revealed that nurses in this study were 'culturally aware' in accordance with the specific assessment criteria used.

The main findings from the study stem predominantly from the qualitative research and the interpretative analysis, in which a number of themes and sub-themes emerged. Qualitative methods consisted of semi-structured individual interviews using a purposive sample from the community nursing population of the area. This allowed for more in-depth exploration of nurses' transcultural experiences.

Nurses tended to be unfamiliar with the professional discipline and practice of transcultural healthcare. Community nurses mostly acquired their transcultural knowledge from their work but tended to undervalue this type of knowledge. Overall, community nurses appeared interested in offering culturally competent care and were aware of the importance of developing and maintaining therapeutic relationships with ethnic minority service users.

Although keen to offer an equality of service, the data demonstrated personal, professional and organisational barriers that led to tensions and ambiguity that impacted on nurses' capacity to further develop their cultural competence. When working with ethnic minority clients, nurses appeared conflicted and complacent at times. In the main, nurses were content to 'just get by'. Nurses were uneasy with some aspects of working with cultural diversity, for example, in the area of the use of language and terminology and this appeared to affect their confidence in addressing issues. A reluctance by nurses to name, acknowledge and challenge racism as a specific form of discrimination within the community nursing service was evident.

Opportunities to improve and build on the development of cultural competence within this environment were identified. A number of practical suggestions for nurses and management are recommended, including practical guidelines, structured formal transcultural placements, education and interdisciplinary collaborative work and research.

Table of Contents

Abstract	1
Glossary of Terms:.....	5
Chapter One: Introduction	12
Introduction & General Background	12
Professional Work-Based Context.....	17
Chapter Two: Aim of Study.....	20
Terms of Reference and Scope of Study:	20
Research Questions and Objectives:.....	20
Literature.....	22
Understanding culture in a changing society	25
Legal and Policy Context: Equality, Discrimination and Racism	29
Interculturalism and Integration.....	33
Health care policy context	36
Experience of Irish Travellers.....	38
Responding to Global Health.....	39
Barriers to progress	46
Cultural Competence & Transcultural Nursing	49
Intercultural Communication	55
Nursing in the Community.....	57
A Critique of Cultural Competence	60
Chapter Three: Methodology and Project Design.....	64
Choosing a Methodology	64
Papadopoulos Tilki Taylor (PTT) Model	68
for Developing Cultural Competence	68
Cultural Awareness	72
Cultural Knowledge	73
Cultural Sensitivity	76
Cultural Competence (Practice).....	78
Measuring Cultural Competence:	80
The Cultural Competence Assessment Tool – (CCAT)	80
Qualitative methods: Semi –Structured Interviews	85
Ethical Considerations	87
Chapter Four: Project Activity.....	94
Quantitative methods: Using CCAT	94
Pilot with CCAT	94
Research Site.....	94
Research Population.....	95
Distribution of Participant Information Sheet (PIS) and CCATs	96
Completed CCATs Returned	96
Qualitative Methods:.....	98
Sampling	98
Data Collection:	101
Pilot Interview.....	103
Semi-structured Interviews	103

Transcribing of Interviews:.....	108
Data Analysis.....	109
Isolating Themes.....	110
Chapter Five: Findings.....	122
Profile of research population.....	122
CCAT: Cultural Competence Levels of Participants:.....	130
Cultural Sensitivity Levels.....	136
Cultural Competence Practice Levels.....	139
Qualitative Data Findings.....	142
Theme One: Experiencing change in local population.....	143
Theme Two: Racism.....	149
Theme Three: Focus on Difference.....	156
Theme Four: Building Relationship and communication.....	162
Theme Five: Professional Preparation and Support.....	173
Chapter Six: Discussion of Study Findings.....	184
Theme One: Experiencing change in local population.....	185
Theme Two: Racism.....	188
Theme Three: Focus on Difference: ‘They and Them’.....	193
Theme Four: Building relationship and communication.....	201
Theme Five: Professional Preparation and Support.....	208
Chapter Seven: Conclusions & Recommendations.....	216
Conclusions.....	216
Recommendations.....	218
Appendices.....	225
Appendix A – Ethical Approval Letter.....	226
Appendix B – Participant Information Sheet.....	227
Appendix C – Cultural Competence Assessment Tool.....	233
Appendix D – Semi Structure Interview Guide.....	241
Appendix E – Practice Guidelines for Cultural Competence.....	243
Appendix F – Transcultural Clinical Placement (Sample).....	254
Appendix G – Project Meeting Agenda.....	255
References.....	256

List of Figures

Figure 1	Papadopoulos, Tilki and Taylor (PTT) Model for Developing Cultural Competence	p.69
Figure 2	Papadopoulos and Lees Culture Generic Culture Specific Model of Cultural Competence	p.70

List of Tables

Table 1	National Action Plan against Racism: Intercultural Framework	p.34
Table 2	Qualitative Findings: Main Themes and Sub-themes	p.121
Table 3	Gender	p.122
Table 4	Religion	p.123
Table 5	Country of Birth	p.124
Table 6	Ethnicity	p.125
Table 7	Overseas Experience	p.126
Table 8	Role in Community Nursing	p.127
Table 9	Post-Graduate Qualifications	p.128
Table 10	Number of Years as Registered Nurse	p.129
Table 11	Number of Years working in Research Site	p.129
Table 12	Level of Cultural Competence	p.130

Glossary of Terms:

Acculturation:

Acculturation is the cultural, social and psychological process of change that occurs between two cultures when they are melded together.

Assimilation:

Assimilation is considered an unsuccessful and discredited social policy including practices / actions aimed at absorbing minority ethnic groups into the majority community.

Asylum Seeker:

An Asylum Seeker is a person seeking to be recognised as a refugee under the 1951 United Nations Convention Relating to the Status of Refugees, to which Ireland is a signatory.

Black:

In describing one's identity, people may describe themselves as Black for a number of reasons. For example, they may describe themselves as such in relation to their physical appearance, their ancestry, heritage, or ethno-history, as a political term or a combination of all of the above. Some people use the word Black to mean, "of African origin"; whereas others mean "non-white" and would include people from Asia or elsewhere. Black is generally not considered to be a derogatory term and in Ireland the term "Black and minority ethnic group(s)" is often used.

Citizenship:

Citizenship is understood as a legal status with associated rights (e.g., access to services, voting, etc.) and responsibilities (e.g., paying taxes).

Culture Shock:

Culture shock is a psycho-social process, sometimes experienced by people who have moved to, passed through, or remained in a social environment or cultural context different from their own.

Discrimination:

Discrimination is defined as the treatment of a person in a less favourable way than another person is, has been, or would be treated, in a comparable situation in any of the nine grounds in Irish equality legislation.

Diversity:

The term diversity is often used to mean the wide range of minority ethnic or black/minority ethnic communities living in a host society. However, a broader usage of the term is now used to refer to the range of individual differences demonstrated among people. Diversity is complimentary to traditional equality approaches that centre on equality in the context of sex, age, and race. Diversity focuses on mainstreaming and includes aspects such as class, ethnicity, educational background, linguistic, mental health, political, or religious beliefs.

Equality:

Equality in the context of this study refers to the state of being equal in opportunities, status and/or rights. In the legal and social context, equality is the term used for “Equal Opportunities”, based on the legal obligation to comply with anti-discrimination legislation. Equality aims to protect people from being discriminated against on a number of defined grounds. Equality does not mean that everyone should be treated in the same way but enables observation and measurement of how people are treated in comparison with other people.

Ethnicity:

Ethnicity is a set of shared social characteristics such as culture, language, religion, traditions, skin colour or physical appearance, that contribute to a person’s or groups’ identity. These characteristics may change over time and are not always confined to or by time and/or location (space). These characteristics are significant and are symbolic markers of difference that enable a group boundary to be preserved and re-produced.

Ethnic Group / Minority Ethnic Group(s).

An ethnic group is defined as a group that regards itself or is regarded by others as a distinct community, by virtue of certain characteristics that will help to distinguish the group from the surrounding community and /or other groups.

Sometimes groups may describe themselves or be described as “Black and minority ethnic group(s)”, this means a group whose ethnicity is distinct from that of the majority population. One limitation of the term “minority ethnic group” is that it can infer that people from a minority ethnic background are immediately identifiable with, or would wish to be identifiable with, a particular group. However, service providers should be aware that this is not always the case.

Ethnic Equality Monitoring:

Ethnic equality monitoring is the process used to collect, store and analyse data about people’s ethnicity and identified ethnic backgrounds. It can be used to highlight possible inequalities and investigate their underlying causes or be used to remove any unfairness or disadvantage. Ethnic equality monitoring must be undertaken ethically and sensitively and not cause any social harm.

Ethnocentrism:

Ethnocentrism is the inherent tendency to consider and believe that one’s own culture is superior to another and to use this as the standard against which all other cultures are judged.

Globalization:

There are many definitions of globalisation. These differ depending on context, i.e., social, economic, cultural, and/or political. However, in general, globalization refers to processes that increase world-wide exchange of resources. For example, ideas, people, finance, communications, technology, knowledge etc. Such exchanges generate an interdependence of economic and cultural activities.

Integration:

As a concept, integration can be seen as a multifaceted, intercultural process that requires the State, majority and minority ethnic communities to work together to accommodate diversity, without glossing over challenges and barriers such as extremism and racism. This differs from assimilation.

Interculturalism:

Interculturalism is essentially about the interaction between majority and minority cultures and seeks to foster the understanding and respect that results in an inclusive society where all members interact, participate and have equal opportunities.

Mainstreaming:

Mainstreaming does not mean there is a “one-size-fits-all” model of service provision. Mainstreaming means ensuring that policies and processes are inclusive of the needs of minority ethnic groups and including consideration of these needs in the planning, implementation and review stages. The awareness of different needs will require the application of different models of service provision.

Migrant:

There are a number of understandings and interpretations of the term ‘migrant’ depending on context, i.e., social, political, cultural or economic. In general, the term migrant can be understood as any person who lives temporarily or permanently in a country where he or she was not born and has acquired some significant social ties to this country. Officially, the United Nations acknowledges that the term ‘migrant’ should be understood as covering all cases where the decision to migrate is taken freely by the individual concerned for reasons of personal convenience and without intervention of an external competing factor. Therefore, this definition of migrant does not apply to asylum seekers, refugees or displaced people.

Migrant Worker:

According to the United Nations International Convention on the Protection of the Rights of all Migrant Workers and Member of their Families, the term Migrant Worker refers to a person who is to be engaged, is engaged or has been engaged, in a remunerated activity in a state of which he or she is not a national.

Migration:

Migration is generally considered the crossing of the boundary of a political or administrative unit for a certain period of time. The variations existing between countries, regions and areas indicate that there are no objective definitions of migration. In general, migration involves either ‘internal’ migration, a move from one area to another within one country or ‘international’ migration which is the territorial relocation of people between nation-states.

Multiculturalism:

Multiculturalism acknowledges the need for the recognition and celebration of different cultures in a society. As a social process it varies from one country to another and has been proven to have limited success. One criticism has been that it allowed for the growth of parallel communities with little interaction between them whilst also glossing over issues such as racism and economic deprivation.

National Action Plan Against Racism (NPAR):

‘Planning for Diversity – Ireland’s National Action Plan Against Racism 2005-2008’ is an official government policy originating from commitments given at the United Nations World Conference Against Racism in South Africa in 2001. It is a plan of action for key areas in public life and services, designed to develop measures to accommodate cultural diversity in Ireland. NPAR uses a whole organisation approach encompassing four components: mainstreaming, targeting, benchmarking and engagement.

Non-National / Foreign National / Non-Irish National:

These terms are increasingly used in Ireland, particularly in a legislative context. However, such terminology can be limited in other contexts. The term ‘non-national’ should be avoided as it is both inaccurate and has negative connotations. The term ‘foreign national’ generally refers only to people who are not EU citizens. Using this term when referring to all migrants may lead to confusion. Non-Irish national seem to be the least problematic in terms of public use and understanding.

Paralinguistics:

Paralinguistics are aspects of vocal and sometimes non-vocal communication that include components such as pitch, volume, speed and accent that go beyond the basic verbal message being delivered. These occur naturally within the socio-cultural context of linguistic development.

Prejudice:

Prejudice involves ‘pre-judging’ by assigning negative, misinformed and ignorant attitudes towards an individual or certain groups, for example, religious or ethnic groups.

“Race”:

The term ‘race’ is a social construct used to classify people. Race is a discredited term. Originally, race was based on a false belief that biologically there were different species of humans, with the implication that some races were superior to others. Scientific research has proved there is no single race-defining gene and therefore, no biological basis for dividing the human population into different races. The term race is still widely used in legislation. In Irish equality legislation ‘race’ is described as “race, colour, nationality or ethnic or national origins”.

Racism:

Racism is a specific form of discrimination and exclusion faced by minority ethnic groups. It is based on the false belief that some ‘races’ are inherently superior to others because of skin colour, nationality, ethnic or cultural background.

Racial Discrimination:

Racial discrimination can be direct or indirect.

Direct – Racial discrimination occurs when a person(s) receives less favourable treatment or outcomes than another person in the same situation would have received on the grounds of their ‘race’.

Indirect – Racial discrimination occurs when a seemingly neutral policy or requirement, action or attitude, actually has an adverse impact on a person from a minority ethnic background. Indirect discrimination can be unintentional.

Institutional Racism – The definition of institutional racism was defined by the UK Stephen Lawrence Inquiry as ‘the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in the processes, attitudes and behaviour which amount to discrimination through the unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people’. Institutional racism relates to the entire institution (systems, policies, procedures, etc.) including people.

Refugee:

According to the United Nations Convention Relating to the Status of Refugees (1951), a refugee is a person who has left their own country and cannot return due to a well-founded fear of persecution on the basis of their race, religion, nationality, political opinion or membership of a particular social group. In Ireland this includes membership of a trade union or having a particular sexual orientation.

Stereotyping:

Generalising about particular minority ethnic groups and labelling them, thus creating false expectations that individual members of the group will conform to certain (often negative) traits or characteristics that have been attributed to the wider group or community.

Targeting:

Targeting is about the development of specific policy and service provision priorities and strategies tailored to meet the needs of minority ethnic groups. Targeting can include, but is not limited to, positive action measures.

Tolerance:

Tolerance was once a commonly used term in relation to inter-ethnic and inter-faith relations. It is now considered inadequate as it assumes the superiority of the persons who tolerate towards the supposedly inferior group / person to be tolerated. Tolerance is most often used in connection with something people do not like. As such, to tolerate another person / group represents a minimum acceptable standard and stands in contrast to ideals such as interculturalism.

Transformational Learning:

Transformational learning is a process of making sense and gaining understanding and meaning from one's experiences. It is a process that involves reflection and critical awareness and one that enables change to occur.

Traveller:

Travellers are an indigenous minority of people documented as being part of Irish society for centuries. Travellers have a long shared history and value system with their own language, customs and traditions. Travellers may or may not be nomadic. Although meeting the sociological criteria of an ethnic group there are differing

opinions and arguments in terms of officially and legally recognising Travellers as an ethnic group in Ireland.

Whole organisation approach:

A holistic approach to address racism and support inclusive, intercultural strategies within an organisation, with reference to equality policies and equality action plans. It is applied across all disciplines, at all levels.

Xenophobia:

Fear or hatred of foreigners or people perceived to be from a different ethnic or cultural background.

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Chapter One: Introduction

Introduction & General Background

Cultural diversity as a reality of people's lives continues to be experienced throughout the globalised world of the twenty-first century (UNESCO 2001). In the context of health and social care, this diversity requires us to consider socially and culturally constructed understandings of health and illness and our responses to them. The consequences of moving beyond biological and bio-medical notions of health and illness will assist in explaining and understanding health behaviour and health care beliefs (Helman 2007). Subsequently, it will also determine how services and professionals respond to meeting the needs of individuals and their communities. As a universal health care profession, nursing is ideally positioned to influence positive change and development in this regard. This limited local study attempts to explore and investigate how public health nurses working in community care are experiencing and responding to this cultural diversity.

The recent downturn in the global economy has seen a significant economic recession in Ireland, resulting in rapid social and political change. One effect of the current recession has been a widespread perception that many health service users with different cultural backgrounds have returned to their countries of origin. In this context, there is a perception that intercultural health issues and the development of culturally competent health care no longer need be regarded as a service planning priority.

Historically, Ireland has been a country of net emigration (Mac Éinrí 2007, Fanning 2011). However, the 2006 Census of Ireland demonstrated an unprecedented growth in population of 8.1% since the previous 2002 census. This increased growth, over just a four year period, was primarily the result of net immigration and it is now estimated that 10-12% of the Irish population is comprised of foreign born nationals.

However, the most recent preliminary findings from Census 2011 (CSO 2012) indicate that long term inward migration rates are set to remain a constant feature of Ireland's development as an EU member. Census data reveals that figures for non-

Irish nationals¹ have increased by 143% in the nine years from 2002-2011. The growth in the number of non-Irish nationals has continued, albeit at a slower pace during the last census period 2006-2011. The number of non-Irish nationals has increased by almost 30%, with some areas statistically more ethnically diverse than others (CSO 2012, Fanning 2011).

Interestingly, other data sources highlight similar demographic shifts. For example, the National Perinatal Reporting System, maintained by the Economic Social and Research Institute (ESRI), in 2009, demonstrated the birth rate of non-Irish born mothers at 25% nationally and also outlined statistics reflecting Ireland as having a birth rate of 16.8 per 1,000 population, the highest in the European Union (ESRI 2009, ESRI 2012). These changes in demographics have a direct impact on health professionals such as community nurses and the types of services they deliver. Therefore, challenges and opportunities exist for health service staff utilising the learning achieved (if any) from transcultural experiences. These include awareness raising and acknowledgment of cultural understandings of health, illness and treatments, consideration of equality of access and the provision of effective language and communication supports. Awareness of culturally competent approaches and planning within organisational governance and leadership is essential (Office of Minority Health 2000, HSE 2008). In considering international migration in a globalised world, the application of these factors may assist staff and organisations in reducing health care disparities associated with social determinants of health and contribute to a clearer understanding of cultural competence and the role it plays in the health care context (Davies et al 2010).

As the capital city, Dublin has changed remarkably in its demography in the past decade, with some areas and suburbs experiencing major growth over a relatively short period of time. The locality where this study was undertaken was the postal district of Liffeside health service area². It is one of the fastest growing urban areas in Ireland with its population growing by over 80% in the past 15 years (Fingal

¹ The term 'non-Irish national' is used by the Central Statistics Office (CSO) to describe those recorded within the Irish Census as being of a nationality other than Irish. A question on nationality was asked for the first time in Census 2002.

² Throughout this report the research site will be referred to as Liffeside health service area. Liffeside is a fictitious location name. Liffeside 'health service area' and 'HSE Dublin' are also fictitious terms used to describe a generic HSE administrative area. These terms are used to protect the anonymity of the research site and the confidentiality of participants.

Development Board 2009). It not only has a rapidly growing population but has seen a far greater increase in ethnic minority communities than the rest of Ireland, with some commentators stating local ethnic demographic change is twice the national average at 20- 21% (Ipsos Mori 2008, FDB 2009, Skokaukos 2010).

Notably, a survey commissioned by the Social Inclusion Measures Committee of Liffeside Area (local government authority), showed that over 50% of the immigrants living in the area had made a decision to settle and make their home in the long term (Ipsos MORI 2008). In addition, another noticeable factor is the proportion of young children in the population of the area, with approximately 9% under five years of age, almost double the amount of other local populations around the country (FDB 2009). The changed demographic profile has considerable implications for how the local health services plan and deliver care. More importantly, it also raises questions as to how health care professionals are responding to these social changes within their working roles and how professionally prepared and supported they are by their employing organisations and educational institutions.

Community public health nurses and the community public health nursing service³ are directly involved at the interface of health care delivery and play a central role in contributing to healthier communities by ensuring that social cohesion and equality informs their practice and the services they provide (Department of Health and Children 2001, An Bórd Altranais 2005). However, for health care workers, the process and practice of ensuring and maintaining social cohesion and equality of access can be complex. It requires an awareness and attention to personal and professional development processes that involves the acquisition and application of knowledge and skills over time (Papadopoulos *et al* 2006).

As Irish society and local communities become more culturally and ethnically diverse, some nurses and health care professionals are encountering issues associated with global and migratory health for the first time in their practice. During periods of

³ For the purpose of this report the term ‘community public health nurse’ refers to Registered Nurses working within the HSE Public Health Nursing Service, under the direct line management of the local HSE Director of Public Health Nursing. This excludes GP Practice Nurses and Community Mental Health (Psychiatric) Nurses. The term community public health nurse is not intended to exclusively refer to Registered Public Health Nurses only. Throughout the report the terms ‘nurse(s)’ and nursing service will be used when referring to community public health nurses and the community public health nursing service.

significant social and economic change, traditionally held values and beliefs come under scrutiny by society. This scrutiny in the context of immigration and cultural diversity often includes a re-examination and interpretation of fundamental issues such as identity, citizenship, cultural self-awareness, rights, freedoms and security. In such circumstances many of these concepts are re-visited, through personal experiences and social influences, such as media reporting, public debates and social-political discourse. This can result in changed understandings, attitudes and behaviours by people in everyday situations, including the places where people work (Fanning 2007, Husband 2008).

Fundamental to ensuring that human rights and equality continue to be part of health service provision and not become challenged, blurred or exclusive, is the idea that professionals are obliged to become familiar with best practice in the area of cultural competence and equality service provision (HSE 2008). However, staff may be unprepared, unwilling and unfamiliar with such developments and unsure of the broader legal implications and how these can affect professional and ethical obligations in practice and how they can in turn have consequences for communities and service users⁴. Alternatively, health care staff such as nurses may be engaged in service provision using interpersonal and professional knowledge and skills. These provide care that produces therapeutic and social value for service users and contribute to the maintenance of health care systems (Gray and Smith 2009). However, many of these aspects of service provision go unnoticed and are not observed or recorded and can sometimes appear to diminish the value accorded to quality care, with attendant consequences for staff and services.

In 2005, an independently commissioned study by the HSE, explored the learning, training and development needs of health services staff in delivering services to

⁴ In this report the term 'service user' is used to describe any member of the public (including people of ethnic minority background) engaged with, utilising, or receiving care, support or interventions from the HSE Community Nursing Service. Recent discourse and debate by President Higgins on the language used by services and the voluntary sector to describe customers and clients as 'service users' has highlighted the risk of disempowering people who use services. This is not the intention of using the term in this report. I acknowledge a core principle of community nursing is to enable and empower people and communities to identify and take ownership of their health and wellbeing through collaboration, participation and active partnership with professional health care services and staff.

members of ethnic minority communities⁵. It indicated that the Irish health services should be required to undertake research, education and training in work based, operational and administrative aspects of cultural competence, citing a significant paucity of evidence on transcultural health care in the Irish health service (HSE/Thrive 2005).

In 2008, observations by the National Consultative Committee on Racism and Interculturalism (NCCRI), based on data gathered by them, relating to public service provision including the health care sector (Watt and Mc Gaughey 2006, NCCRI 2008), also revealed a lack of research, policy, legislation and services specifically addressing discrimination and inequality specific to ethnic minority groups.

The increase in population and cultural and linguistic diversity has resulted in particular challenges in some health services. Emerging trends indicate that inconsistencies and gaps exist across the Irish health services in the provision of appropriate standards of intercultural communication for culturally and linguistically diverse groups, including for those people with limited English proficiency (NCCRI 2008, Mac Farlane et al 2009). This is evident across the spectrum from primary health care to hospital based care and is reported by service user groups and local health services. A question on foreign language was asked for the first time in the National Population Census in 2011. Although preliminary census data reveals a diversity of languages used and spoken within the Irish population (HSE 2012), there remains no systematic information available with which to assess language needs across the public health system. Consequently, this makes it difficult to fully assess the interpreting and translation requirements of services (NCCRI 2008).

Some health care facilities and professionals simply accept that language barriers and cultural misinformation are par for the course and are the expected norm. In general

⁵ Throughout this report the terms ethnic minority and ethnic minority group / community, (at times also described as minority ethnic group) will be used in keeping with the definition and understanding of the HSE Intercultural Strategy and National Consultative Committee on Racism and Interculturalism who describe them as follows: a group who's ethnicity is distinct from that of the majority population sometimes described as 'Black and minority ethnic group(s)'. The term ethnic minority is sometimes used, but the term 'minority ethnic' draws attention to the fact that there are majorities and minorities all with their own ethnicity. A limitation of the term minority ethnic group is that it can infer that people from a minority ethnic background are immediately identifiable with or would wish to be identifiable with a particular group.

they are content just to 'get by'. However, it must be acknowledged that a level of language proficiency sufficient to enable a person to get by in everyday situations may not be sufficient to meet the demands of a clinical health care encounter (Robinson and Philips 2003, Rosenberg et al 2007). The World Health Organisation (WHO 2010) Council of Europe (2006), Office of Minority Health and Human Services (2001, 2013) acknowledge these as problems and challenges within the health sector universally. In the long-term, if left unaddressed, these are likely to undermine the quality of care and could lead to possible adverse events such as misdiagnosis or unnecessary treatment (Davies 2010, Crossman 2010). In addition, it is unethical, unprofessional and in some circumstances illegal. In 2007, the HSE produced the National Intercultural Health Strategy 2008-2012, with the intention of addressing some of these issues in the Irish health service.

Professional Work-Based Context

Since my appointment in 2000 as Clinical Nurse Specialist (CNS Asylum Seekers Health), my post remains to date, the only designated nurse specialist position for a specific migrant population within the Health Service Executive. Although primarily based within a refugee accommodation and health centre, I only had limited interactions with other community nurses in the general primary care setting. Consequently, I considered it important to undertake a local exploratory study in an effort to ascertain some baseline information on the transcultural experiences of community nurses and the development of cultural competence.

Officially, the CNS role encompasses five core components and areas of responsibility as defined and regulated by the National Council for the Development of Nursing and Midwifery (NCNM 2004, Doody and Bailey 2011). These core components are as follows:

- Client Focus (clinical group - Asylum Seekers, Refugees)
- Client Advocacy (speciality area / other agencies)
- Education & Training (client group & multidisciplinary health team)
- Audit & Research (clinical practice and policy)

- Consultant (multidisciplinary / other agencies)

From my work experience I have learned that increasing international mobility in an age of globalisation also means that the nature of illness and disease, including people's understandings of illnesses, access to health care and service utilisation, is also changing (Davidson et al 2003, Drennan 2005, Pace 2010).

Consequently, health services and staff including nurses are experiencing the impact of such changes. The rationale underpinning this study is that there is a paucity of empirical research that explores the transcultural health and / or cultural competence experiences of community nurses from within the discipline of Irish community nursing.

The community nursing service in Ireland is changing significantly and rapidly in response to population health demands, technological advances, demographics and societal changes (Leahy –Warren 1998, Clarke 2004, Nic Philbin 2010). As a Clinical Nurse Specialist working in the area for the past twelve years, I feel I can make a positive contribution to promoting transcultural care within the nursing and general health care environment (Jeffreys 2002, Jeffreys 2005). According to the Office of the Nursing and Midwifery Services Director (ONMSD 2012), public health nursing services operate at the coal-face of community care, responding to population changes and organisational reform in health care. These responses need to be investigated and evaluated and may need to change. Rather than a reactive response, the pro-active planning and implementation of appropriate services requires knowledge and information. Therefore, some baseline exploratory research is required from within the different disciplines. This study attempts to gather such information in the context of cultural competence in public health nursing.

There is a likelihood that the type of biomedical Westernised nurse training that predominates in nurse education, culture and practice provides little transcultural knowledge or opportunity for critical reflection on socio-political constructions and interpretations of the human cultural encounter. Therefore, such an approach may contribute to an ethnocentric application of health care, possibly resulting in discriminatory or racist care provision (Tilki et al 2007, Markey et al 2012).

Knowledge of cultural diversity is necessary at all levels of health care practice. Ethnocentric biomedical approaches will prove ineffective in meeting the needs of culturally diverse individuals and communities. Concepts of illness, wellbeing and treatment are derived from people's world views or learned cultural perspectives. Therefore, knowledge, skills and experience about the complex interactions between culture, health and illness, including health seeking behaviour, is essential, not just for health care practitioners but for health educators, administrators, managers and leaders within health care organisations (Foley and Wurmser 2004).

What is required is knowledge of and analysis of nurses' experiences that can inform future developments in transcultural nursing within the Health Service Executive at a local level. In responding to social change, nurses are well placed to lead on national health care issues, if prepared and encouraged to do so (Department of Health and Children 2003, Carney 2009, Brady 2010).

This study was undertaken during the latter period of the timeframe for the National HSE Intercultural Health Strategy (NIHS) 2007-2012. However, in my experience, even at local HSE level, there does not appear to be any formal mechanism for specifically developing transcultural nursing within the HSE community nursing service (ONMSD 2012).

By participating in transcultural research it is my belief that community nurses are ideally placed to direct and inform professional service development that is not just nursing specific. Based on their unique practice environment of working in people's homes and communities, the experiences of their wider socio-cultural interactions and interventions can inform a more politicised and wider understanding of transcultural community health.

By building upon already existent knowledge and skills and acquiring cultural competence knowledge, nurses can assume professional leadership roles and contribute towards a more collaborative and effective care service for the increasingly diverse communities they serve.

Chapter Two: Aim of Study

Terms of Reference and Scope of Study:

The terms of reference for undertaking this study stem primarily from my position as outlined in the previous section.

This study proceeded within the parameters and criteria for undertaking a work-based research project. Continued awareness and application of the Level Five criteria⁶ were a key element when undertaking the project, enabling me to understand the broader political work-based environment. Adhering to these criteria, the research process evolved to recognise barriers and identify implementation strategies to achieve sustainable change at a personal, professional and service level. However, in compiling this report I struggled and found it difficult to achieve the desired outcome within the limitations laid down. Although a local study is limited in its generalizability, the research process and learning outcomes from it can inform a broader constituency of stakeholders and professional disciplines, working locally in Liffeside and within the HSE organisation as a whole. Many of these are later outlined in the recommendations section.

Research Questions and Objectives:

This project set out with the aim of evaluating and gathering information on the transcultural experiences of nurses working in a changing community health environment. By acknowledging and exploring previously undocumented or identified gaps in practice and policy, including the literature, it was anticipated that this study would inform the continuing development of a more culturally congruent community nursing service in Liffeside HSE Dublin. This included planning for the resource, educational and professional development needs of community nursing staff and exploring opportunities for further research.

Using mixed research methods the study aimed to elicit information from the impact (if any) that increasing ethnic demographic change had on nurses and their practice in the local HSE area. A quantitative research survey (Cultural Competence Assessment

⁶ The Level Five Descriptors (Criteria) for the DProf Programme are as follows: Ethical Understanding, Knowledge, Professional Practice, Project Development, Communication,, Reflection and Self-Appraisal, Collaborative Working, and Resource Management.

Tool (CCAT) to evaluate levels of cultural competence was employed, along with qualitative methods (individual interviews) to investigate and explore transcultural experiences. The study intended to produce data demonstrating competencies at an individual level, including issues related to the delivery of the nursing service in the area.

The research questions underpinning the study were as follows:

1. What has been the experience of nurses in responding to a change in the cultural and ethnic demographic of the local population?
2. What are nurses' understandings of cultural competence and transcultural nursing?
3. How prepared and supported are nurses in delivering care to an ethnically diverse population?

Using the Cultural Competence Assessment Tool (CCAT) the quantitative research objectives of the study were:

- To gather a profile of the background of nurses in general and in relation to transcultural nursing experience / training / education.
- To assess the levels of cultural competence of nurses, as per the CCAT.
- To assess the knowledge and skills of nurses in cultural competence through self-rating.

The objectives of the qualitative research component were:

- To explore in depth, the experiences of nurses working with a population undergoing a rapid ethnic and cultural demographic change
- To explore in depth, the nurse's understandings of cultural competence and transcultural nursing
- To explore nurses' attitudes and behaviours in response to cultural issues in their practice

- To explore existing skills and/or skill development of nurses working in a culturally diverse setting
- To identify the extent of preparation and training received by nurses in the area of cultural competence

The rationale for utilising these research methods will be outlined in greater detail in the design and methodology section of this report.

Literature

From my work based experience within the field of asylum seekers' health, I have observed a paucity of empirical transcultural health studies across the health and social care disciplines within an Irish and HSE organisational context. This has also been noted by other authors in the area (Markey et al 2012, Donohue 2010, Mac Farlane 2009, Lyons et al 2008, Touhey et al 2008), including in other health care professions such as general practice medicine, public health and psychology (Peiper 2009, Toar 2009, Skokaukos 2010). This is unsurprising and to be expected as the increasing demographic change occurred over a relatively short period of time. Another impediment to developing a scientific research base of transcultural health studies in the Irish context relates to the absence of a centralised national method of ethnic equality data collection in the Irish public health service (Health Service Executive). Consequently, literature on transcultural health in other European and international contexts was considered. Where relevant within the scope of this study, reference was also made to literature concerning reflective practice, research methods and leadership.

A systematic review of literature was undertaken. Due to my professional role, I had membership access to a number of professional libraries including the Irish Nursing and Midwifery Organisation Professional Development Centre Library, An Bórd Altranais (Irish Nursing Board) Library, the HSE Staff Library and LENUS (HSE Health Research Repository).

I accessed and reviewed literature based on specific criteria. This included a time frame on publication dates and the use of keyword searches. Peer-reviewed research

articles including commentaries from professional journals, both national and international, within a specific time-frame (2000-2010) were also utilised.

It was intended that the specific time frame applied to the published literature would assist in a number of ways. Firstly, for pragmatic purposes to suit the size of the study. Secondly, to ascertain the influence (if any) of cultural demographic change on healthcare professionals by observing the amount and type of research emanating from the Irish health service during this period. Thirdly, the time period chosen reflected the length of time I was working as a nurse with refugees and asylum seekers within the HSE organisation. Although keen to remain within the assigned time period for publications, on occasion I found myself deviating from this, particularly if an article or text was of specific relevance to public health nursing / community nursing.

The literature accessed was primarily from within the health and social care disciplines including nursing, medicine and global health. Apart from scientific healthcare journal articles, other types of literature included text books, government and non-government policy documents and publications.

In the main I searched on-line professional databases that generated a significant amount of literature. When undertaking searches on these databases I, on occasion, found myself having to use synonyms and alternative spellings, as some used different terminologies, language and spellings.

The databases I used were, Cumulative Index to Nursing and Allied Health Literature (CINHAL), Medline, Pubmed, and Internurse as these provided access to current research articles in professional peer reviewed journals. Keywords I used included, *'transcultural nursing'* *'cultural competence'* *'migrant health'* *'community nursing'* and *'public health nursing'*. To broaden the literature search I accessed literature relating to interculturalism and public health from related disciplines of sociology, anthropology, educational studies, research methods and community development studies. Searches in these categories were also undertaken using the same criteria. Keywords used in accessing this type of literature included, *'healthcare and human rights'* *'culture'*, *'ethnicity and health'* *'migration'* *'racism'* and *'integration'*. The purpose of this broader search was to consider the educational and community

development aspects of primary health care within the transcultural context, aspects that are not ordinarily explicit in professional health care studies.

In addition to accessing literature in health care libraries, I had also built up a significant information base of literature from my work-based practice. Of note were a number of published research reports and commentaries addressing ethnic minority experiences in the context of social inclusion and community development. Historically most of this ‘grey’ literature emanated from the voluntary and non-governmental sector, including community based organisations advocating for the rights of ethnic minority or immigrant communities. Over the years in my role I had worked collaboratively with some of these organisations on various refugee health projects. This provided me with a significant amount of information specific to the local context, as much of this literature concerned the field of migration, social justice, human rights in Ireland. Typically, many of the reports contained experiences from migrants, refugees and asylum seekers and addressed factors related to the social determinants of health⁷ such as accommodation, access to services and integration including experiences of discrimination (Cáirde 2006, FLAC 2009, ICI 2011, Arnold 2012). I considered these relevant in the context of the ethnic and cultural diversity in Liffeside and also due to the fact that there were accommodation centres for refugees within the area.

As a nurse working specifically with asylum seekers and refugees within the community development context, I regarded this type of literature to be of pivotal value. I considered it important to draw upon this literature in order to discern how transcultural nursing can contribute towards the development of culturally competent primary care services in the local HSE area and within the organisation. This was particularly significant in considering collaborative community development approaches with ethnic minority communities in order to address primary health care service provision. Drawing on the chosen literature, the following section attempts to outline the overall context for undertaking this study.

⁷ The World Health Organisation (WHO) considers the social determinants of health are the conditions in which people are born, grow, live, work, and age – including the health systems. These circumstances are shaped by the distribution of money, power, and resources at global, national and local level. The social determinants of health are mostly responsible for health inequities, such as the unfair and avoidable differences in health status seen within and between people in societies.

Understanding culture in a changing society

As in all societies, a fundamental part of how we see and understand ourselves and others, including how we interact with our environment, is influenced by our understanding of the concept of culture and how we develop a cultural identity (Helman 2007, Kottak 2004). Culture is an integral part of each of us, rather than a set of characteristics associated with those whom we regard as different from ourselves.

According to anthropologists Kroeber and Kluckhohn (1952), culture consists of patterns of acquired behaviour and transmitted symbols, constituting the distinctive achievement of human groups, including their embodiment in artefacts. Kroeber and Kluckhohn claim the essential core of culture is composed of historically derived and selected ideas and especially their attached values.

Generally, within the literature, there is a standardised type of definition for culture that is commonly described as being a set of learned and shared values, beliefs, norms and behaviours that provide a collective understanding and meaning to the experience of living within a particular group or community.

For me the socio-cultural changes in Ireland over the past decade, primarily as a consequence of increased inward migration, have influenced the development of my understanding of culture and more importantly its place within my professional role. Therefore, for the purposes of this research project, I have considered the definition of culture defined by Zygmunt Bauman (1999) that demonstrates the fluid nature of culture and locates it within an increasingly globalised context:

“Culture is as much about inventing as it is about preserving; about discontinuity as about continuity; about novelty as about transcendence of norm; about the unique as much as about the regular; about change as much as about monotony or reproduction; about the unexpected as much as about the predictable.”

(Zygmunt Bauman 1999)

I have learned that working in a multicultural health care environment where one encounters a diverse range of cultural ways of living, requires critical reflection at a personal and professional level. If this does not occur it could negatively influence how care is administered and how relationships develop. Many commentators within

health care acknowledge that narrow definitions and fixed understandings of culture such as cultural reductionism, in respect to difference or distinct ethnicities (ethnic sensitive model), can lead to stereotyping of people and their ways of living (Gerrish 2001, Gustafson 2005, Culley 2006). This is often unintentional and unconscious and such understandings are generally borne out of limited experiences, a lack of formal knowledge and perhaps a limited motivation or opportunity to reflect on culture in the health care and nursing context.

Consequently, there is a need for nurses to examine and challenge their own understandings of culture, cultural awareness and ethnocentrism (Leininger 1995, Camphina-Bacote 1999, Papadopoulos 2006).

Fanning (2011) and others have suggested that until relatively recently, Irish society considered itself an indigenous mono-cultural majority population where there was no perceived need to define ourselves against others within the geographical and social boundaries of Irish society (Lentin and Mc Veigh 2002, Watt 2008).

During that period (2000-2006), notions of Irish identity and strongly held beliefs previously constructed from the historical and traditional experiences and influences of colonialism and pre-and post-Independence began to change. A new Irish cultural identity was being shaped by political and media influences in the early to mid 2000s (Mac Einrí 2007). Markers of Irish identity closely associated with Irish nationalism such as religion, language, politics were shifting, particularly following the Belfast Agreement 1998, the expansion of the European Union in 2004 and continuing globalization.

In 2004, the Citizenship Referendum and the discourse surrounding it in the context of specific notions of what it meant to be Irish, culminated in distinctions been drawn between nationals and non-nationals, citizens and non-citizens. A tension and hostility around issues of cultural diversity such as race, ethnicity, culture, immigration, asylum seeking and refugees emerged. In effect, social discourse in response to the change became more politicized and in some instances racialised (Lentin and Mc Veigh 2002). Fanning and Mutawarsibo (2007) commented on the Irish response to immigration within a 'xenophobic' (fear of foreigners) discourse.

Similar debates and considerations are evident in other jurisdictions such as the UK and EU countries. In some cases there is a risk of denying the fundamental human rights of vulnerable people such as ethnic minority groups, or irregular or undocumented migrants due to the interpretation of rights by national governments based on citizenship or non-citizenship conditions (Tilki et al 2006, Fountain et al 2007, Husband 2007, Aspinall 2010). This includes access to and the availability of, appropriate culturally competent and transcultural health⁸ care to meet the specific needs of individuals and communities.

Fundamental to the discourses about ethnicity and ethnic minority issues is the concept of difference and how it is interpreted. The use of social constructs such as race and ethnicity can create categories or divisions of 'others' in society. Theoretical frameworks that attempt to explain these concepts refer to the 'self-other' or 'us-them' dynamic. Othering as a term has been described as the denial of equal legitimacy to individuals and cultures that do not conform to ones' own arbitrary, ever-shifting criteria of normality (Lentin and Mc Veigh 2002).

Interestingly, Ryan (2007) in a study exploring the construction of ethnic identity amongst Irish nurses in Britain through their encounters with other ethnicities, made a number of observations. By investigating the 'spaces and places' where ethnic identities were being constructed by Irish nurses, Ryan concluded ethnicity to be a dynamic and fluid concept, informed by the process of migration, the encountering of not only other ethnic groups but also including the experiencing of one's own identity in a series of new spaces and places. Through interactions with the host society and institutions, including a society of peers from the country of origin, the study revealed how nurses came to understand and overcome stereotypical notions of Irish identity. The study highlighted how ethnicity is generally considered within the narrow black/white colour paradigm, often excluding the more significant social construction of ethnicity as it relates to all. In the context of this study, undertaken with immigrant Irish nurses in the United Kingdom, it raised further questions about how nurses had

⁸ Cultural Competence and Transcultural Health care (including transcultural nursing) are terms used separately and interchangeably throughout this report. Some theoretical, philosophical and organisational differences exist in and between the use of each term. For this report, understandings of these terms are derived primarily from the nursing literature. This will be explained in greater detail later in this report under the heading 'nursing context'.

been socialised prior to arrival from Ireland where health care and nursing culture were predominantly entrenched in the dominant socio-cultural norms of the time. This was significantly influenced by the role of the Catholic Church in Ireland who owned many of the health care institutions and provided and administered professional health education to nurses and midwives (Yeats 2009).

What are also interesting and relevant in the context of this study are the nurse migration patterns that have occurred in Ireland in the past decade, where the nursing population within the Irish hospital sector has seen a disproportionate increase in the recruitment and immigration of international nurses. Humphries et al (2009) have been critical of the dearth of official data gathered concerning migrant nurses in Ireland and state that a decade on from significant international recruitment some basic questions still require to be answered such as: how many migrant nurses currently work in Ireland? In what fields of nursing are they working in? What skills and experiences did they bring to Ireland and are these being utilised? In the context of this local study it is worthwhile considering the impact, if any, from this international nurse migration on community nursing and the subsequent development of cultural competence in the local context.

In academic discourse the term ethnic minority group is used frequently. The concept of ethnic minority grouping is influenced by social context and the majority perspective. The majority perceive a member of an identifiable minority group as different; whereas, someone who identifies themselves as being in a minority group does not see themselves as any different to their group members. The construction of minority identity is complex and is informed by many factors, including social, political and psychological. However, it is useful in the context of understanding ethnic minority issues in health care. What is often understood by theorists to be a defining element in minority identity is the common experience of oppression (Atkinson et al 1993). However, within the health care context the WHO (2010) acknowledges that many health interventions tend to focus on a deficit approach – exploring problems and specific needs of minority ethnic groups, rather than focusing on the assets and strengths that they possess for creating, maintaining and safeguarding their own health (WHO 2010).

Cultural features and markers of ethnic groups may include a collective name, a sense of solidarity, and an association with a specific territory or homeland. Such shared beliefs may result in values, customs and norms within the group and ethnic feelings of intensity that can change over time for the individual or the group depending on circumstance. These differences exist not just socially but can also manifest in physical and biological terms, influencing the health seeking behaviour of people and health care outcomes (Tilki 1998, Helman 2007).

However, before outlining the health care and transcultural nursing context, I will briefly describe some of the relevant general political and social policy relevant to this study.

Legal and Policy Context: Equality, Discrimination and Racism

Ireland has a broad range of legislative, administrative and institutional human rights instruments that intend to address equality and safeguard against discrimination. It is beyond the scope of this study to allow for an in-depth analysis of the impact of these on community nursing and health services in general. However, a limited understanding of them is implicit in the report and brief mention of same is made in the context of the nature of this study. Similarly, an awareness of Ireland's obligations under various European Union, United Nations and other International covenants and instruments, including professional nursing position statements outlining nursing obligations from a human rights perspective (Council of Europe 2006, WHO 2010, ICN 2008), also informed this study.

Historically the Government of Ireland has stated that it is committed to acknowledging and promoting equality, including differences as mentioned in Article 40.1 of the Constitution:

“..All citizens shall as human persons be held equal before the law. This shall not be held to mean that the State shall in its enactments have due regard to differences of capacity, physical and moral and of social function.”

(Bunreacht na hÉireann 1937)

In more recent times this commitment to an inclusive society and the elimination of all forms of discrimination has also been legislated for. There are two distinct pieces of legislation that set out distinct rights and specifically outlaw discrimination when it

occurs i.e., The Employment Equality Acts 1998-2011 and the Equal Status Acts 2000-2011.

Ireland signed the United Nations Convention on the Elimination of All Forms of Racial Discrimination – (UNCERD) in 1968 (Government of Ireland 2009). The Convention was ratified by Ireland and entered into force in 2001, following the enactment of The Equality Act 2004 which transposed the EU Racial Equality Directive into Irish Law.

Under the Employment Equality Acts 1998-2011 and the Equal Status Acts 2000-2011, discrimination has a specific meaning. It is described as the treatment of a person in a less favourable way than another person is, has been or would be treated in a comparable situation. Discrimination based on any one of the nine distinct grounds is unlawful. These grounds are: *gender, religion, civil status, family status, sexual orientation, age, religion, disability, 'race', and membership of the Traveller community*. These Acts prohibit direct and /or indirect discrimination⁹ (including discrimination by association).

The field of application of the Equality Legislation is very broad, covering prohibition of discrimination in employment and occupation and prohibition of discrimination in the access to and supply of goods and services. The Equality Authority is the body charged with the promotion of equal treatment in Ireland.

In the Equality Legislation the 'race' ground is interpreted and stated as covering 'race', skin colour, nationality and ethnic or national origin. In the Irish context racism is described by the National Consultative Committee on Racism and Interculturalism (NCCRI 2007) as a specific form of discrimination and exclusion faced by minority groups. Racism is based on the false belief that some 'races' are inherently more superior to others because of different skin colour, nationality, ethnic or cultural background. In Ireland, discrimination on the grounds of 'race' can be categorised for investigation under equality law, criminal law, or both.

⁹ Indirect discrimination refers to discrimination that happens where there is less favourable treatment in effect or by impact. For example, it happens where people are refused employment / training or a service, not explicitly on account of a discriminatory reason but because of a provision, practice or requirement which is found hard to satisfy.

Although internationally the term ‘race’ is now officially acknowledged as a discredited term and concept, it continues to be used in academic, legal and social discourse. The historical use of the term implied a conscious and unconscious understanding of superiority on an ideological basis. It propounded a set of beliefs justifying the oppression of people based on perceived inferiority that was understood as a biological genetic construct. These theories were fuelled by historically inaccurate and misinformed medical science. This contributed towards negative sociological constructions and interpretations of race, resulting in the abuse of power by one group over another. Race and racism served as codes of power politically, economically and socially, resulting in inhumane and degrading treatment of human beings (Kottak 2004, Fanning 2007).

In the context of undertaking a study on cultural competence it is important to understand the phenomena of racism. The internationally accepted definition of racism clearly indicates that it is more than a set of attitudes or prejudice and a specific form of discrimination associated with skin colour and ethnicity: e.g. UNCERD (1968);

“Any distinction, exclusion, restriction or preference, based on race, colour, descent, national or ethnic origin which has the purpose of modifying or impairing the recognition, enjoyment or exercise on an equal footing, of human rights and fundamental freedom in the political, economic, social, cultural or any other field of public life, constitutes racial discrimination”

A report by the Equality Authority and ESRI (2010) on experiences of discrimination in Ireland in different social and service contexts demonstrated a serious risk of discrimination to those in Black Ethnic groups between 2004 and 2010 (Equality Authority 2010). Although an increase in incidents of racism, as experienced by people of diverse backgrounds living in Ireland in 2008, was demonstrated in the European Union Minorities and Discrimination Survey (EU – MIDIS) (Fundamental Rights Agency 2009); of concern in the report was the poor data collection methods and reporting procedures in a number of EU countries. Specifically, within the Irish public health system there remains very little empirical research or published studies on racism in health care provision or within the professional disciplines.

Therefore, in the context of public service provision, a particular concern exists about how racism can manifest itself within organisations including healthcare systems. As

Ireland is a relative newcomer to race relations, much can be learned from the experiences of other jurisdictions and countries where cultural diversity and associated race relations have been well established. An example of how learning and developmental change can occur within organisational systems is demonstrated in the United Kingdom's Stephen Lawrence Inquiry and its recommendations (Macpherson 1999). In 1993, Stephen Lawrence, a young Black man was killed in an unprovoked racist attack by five white youths in London and nobody was convicted of his murder. A Judicial Inquiry came about, following a persistent campaign by the Lawrence family to ensure an examination of the procedures and practices of the police investigation. The Inquiry's overall aim was the elimination of racist prejudice and disadvantage and the demonstration of fairness in all aspects of policing (Macpherson 1999). The Inquiry revealed significant levels of 'institutional racism', combined with professional incompetence and a lack of leadership. Seventy recommendations in keeping with the overall aim were put forward by the inquiry team. Since its publication, some commentators have critically reviewed attempts to implement the recommendations of the report and have drawn attention to the continuous need to ensure that reform occurs (Rollock 2009). They include the need for effective practice of recording racist incidents, improvement in monitoring racially motivated incidents and the sharing of information. It is also recommended that public scrutiny should continue beyond the publication of an inquiry report, ensuring greater coherence and transparency by agencies and government in implementation and follow-up. These key areas have significance and relevance for all public services, not just for policing.

There is much to be learned in the health care and nursing environment from such recommendations. However, in order to engage such a response, what is required in the first instance is a commitment by people within healthcare organisations and professions to acknowledge the existence of racism within health services. What is also required is a scientific and robust system for gathering ethnic equality data, to ensure accountable and appropriate responses to issues of diversity in community nursing and health care. This will be explored later in the section on cultural competence and transcultural nursing.

Interculturalism and Integration

As the period following the enactment of the Equality Legislation 1998-2011 coincided with significant demographic change (primarily related to inward migration), the Belfast Peace Agreement, European Union expansion and a period of economic prosperity – the government introduced a number of key policy instruments to assess the extent of cultural and ethnic diversity and to provide benchmarks for planning.

The *National Action Plan Against Racism (NAPAR)* - ‘*Planning for Diversity 2005-2008*’ was developed in response to commitments given by Ireland in 2001 at the UN World Conference on Racism in South Africa. The Plan was developed by the NCCRI using an intercultural framework model, focused in integration (Government of Ireland 2005).

A key assumption with this approach is that ethnic diversity can enrich society, without glossing over issues such as ethnocentrism, xenophobia and racism. As a starting point, the approach acknowledges that the culture of the minority group is important and requires recognition and acceptance, while also focusing attention on an awareness of the accepted norms within the dominant culture. Of key importance in the development of this approach is the opportunity for continued interaction between the dominant and minority ethnic communities, allowing for reflection on issues of power and decision-making in society and examining how these are distributed and organised (NCCRI 2007).

In general terms the intercultural framework is based on five key objectives, outlined in the table below:

Table 1: Intercultural Framework:

1. Protection	Effective protection and redress against racism
2. Inclusion	Economic inclusion and equality of opportunity
3. Provision	Accommodating diversity in service provision
4. Recognition	Recognition and awareness of diversity
5. Participation	Full participation in Irish society

Source: Planning for Diversity: The National Action Plan Against Racism 2005-2008, Department of Justice Equality and Law Reform, 2005.

Although the main aim of the NAPAR is to provide strategic direction to combat racism and to develop a more inclusive society, it is also intended to influence broader equality, anti-poverty and public service modernisation policy. The key objectives of the intercultural framework approach are closely related to some of the principles required for the application of culturally competent health services and transcultural nursing and are, as such, relevant to this study. These principles will be outlined later in this report.

The underpinning assumptions of the intercultural approach adopted by government policy in Ireland differed from the multicultural approach utilised in Northern Ireland and in the UK (Watt 2007). Multiculturalism was criticised for continuing to advocate the perhaps unfair and unrealistic responsibility placed upon minorities themselves to change and adapt in order to succeed, while at the same time, minority and majority groups were expected to be tolerant of each other. The notion of toleration as a means to improve better community relations failed to acknowledge the existence of inequalities or discrimination and the need to challenge negative attitudes and practices (Fanning 2011). Indeed, for tolerance to be necessary a prior belief must exist that those to be tolerated have intrinsically undesirable characteristics or that they are not fundamentally entitled to the benefits which are to be allowed them (as those afforded to the majority). Therefore, those to be tolerated possess some social stigma, mostly derived from politics of difference (Husband 1994, 2007).

Of particular importance in developing and achieving an intercultural society, as opposed to a multicultural society, is the reasonable accommodation of diversity and the application of positive action. This primarily involves taking account of the practical implications of cultural diversity in the design and implementation of policies and organisational practices and making the necessary adjustments or changes to secure inclusion for ethnically and culturally diverse people. In order to secure full equality in practice for minority groups, this requires targeting resources to address the specific needs of minority ethnic groups and creating conditions for their participation in mainstream provision (NCCRI 2007, Mac Éinrí 2007). Transferability of this approach into the health sector evolved in the form of the HSE National Intercultural Health Strategy 2007-2012. This will be briefly outlined in the health policy context section.

The *National Action Plan for Social Inclusion 2007-2016* is intended to draw attention to particular vulnerable groups including Travellers, migrants, and members of ethnic minority groups in the context of reducing and eliminating poverty. Acknowledging that poverty as a concept is complex and seen primarily as the result of structural faults in society, the relationship between poverty and forms of discrimination such as racism, is multifaceted. While not all poverty involves racism and not all racism involves poverty, it has been established that both can exacerbate each other. In an Ireland where ethnic and cultural diversity is an increasing component of community development, attention ought to focus on how resources and opportunities are mediated and distributed, to ensure fair and equal treatment (NCCRI 2007).

Working as a nurse with asylum seekers since 2001, I have observed no commitment by government to improving the situation of this group, such as increasing the Direct Provision payment allowance, allowing access to employment or fulltime adult education. This is despite repeated calls based on research findings, revealing increasing levels of poverty, poor mental health and increasing social exclusion amongst asylum seekers (Smyth & Whyte 2005, Peiper 2009, FLAC 2010, Arnold 2012).

Health care policy context

Although developed in 2001 prior to the peak in diverse ethnic demographics the National Health Strategy '*Quality and Fairness - A Health Service for You*' (Government of Ireland 2001a) acknowledged the need for health services to meet the specific needs of local communities and briefly mentioned the move towards a more multiethnic society including the need to plan for diversity. In addition the *National Primary Care Strategy - A New Direction* (Government of Ireland 2001b) made passing reference of the need to be inclusive of the changing demographics of Irish society and to keep services patient-centred;

“Primary care needs to become the central focus of the health system.....primary care should therefore be readily available to all people regardless of who they are, where they live, or what health and social problems they may have.” (Government of Ireland 2001a p.7).

In particular the primary care strategy acknowledged that community participation in primary care would be strengthened by encouraging and facilitating the involvement of the local community and voluntary groups in needs assessing planning and delivery. Indeed a decade later these strategy documents remain the reference point for the continuing development of health services. However, while a number of action points within the Primary Care Strategy pertain to meeting the health and social care needs of specific populations within geographical areas, little in the way of practicable guidance for developing culturally competent health services or facilitating transcultural development for staff has been forthcoming. Consequently, initiatives began to be undertaken by health care service providers, to address transcultural health issues that were arising in practice at local and regional level (NCCRI / IHSMI 2002, ERHA 2004, HSE 2008).

In 2004 the Eastern Regional Health Authority (ERHA) published a regional health strategy for ethnic minorities. The ERHA Regional Ethnic Minority Strategy aimed to ensure the provision of excellent, equitable, appropriate, people-centred health and social care to all persons of ethnic minority groups. Implementation of this was to be a significant milestone towards attaining the vision of the National Health Strategy. A number of key areas were identified for specific attention including: health promotion, primary health care, health screening, sexual health, mental health, maternity care,

child health, inter-sectoral collaboration, communication, staff support and development, managing multicultural workforces and identifying and harnessing the capabilities of new communities. Significantly, the public health nursing service was identified as a key component for the successful implementation of the strategy actions (ERHA 2004).

Following the creation of the Health Service Executive (HSE) in 2005 as the single national provider of public health services in the State, a national approach to addressing intercultural health care was called for. The National Care Group Social Inclusion Division (HSE Eastern Region) undertook a national scoping research project on the learning, training and development needs of health services staff in delivering services to members of minority ethnic communities (HSE /Thrive 2005). On completion, the report identified a number of initiatives that needed to be established, incorporating organisational ethos, work place environment and service elements necessary to support intercultural training. However, service development aspects were outside the remit.

Consequently, in addressing service provision, the HSE National Intercultural Health Strategy (NIHS) 2007-2012 was devised and published in 2008. Having emerged from obligations incurred by the health sector in the National Action Plan Against Racism '*Planning for Diversity*', the development of a national health strategy to address issues of cultural diversity within the health and social care sector remains a relatively new field.

Although key areas for attention were based on the same framework as the 2004 ERHA strategy, a greater emphasis in developing the NIHS was placed on community participation and consultation with relevant stakeholders and civil society. Four main priorities emerged from the consultation process:

1. Information language and communication: improve access to information and cultural mediation: provide professional interpretation and translation service and the provision of training for community interpreters.
2. Service delivery and access to services: services to be provided on the basis of equality of access in all areas of service provision; provide better systems for inter-sectoral work and co-ordination of services and develop a population

health approach that links to the social determinants of health and health inequalities.

3. Changing the organisation; ensure that the organisation reflects the diversity of Irish society; ensure commitment in the leadership of the organisation to interculturalism and equality; enhance learning and staff development and improve data collection.
4. Working in partnership with ethnic minority communities: support and provide resources for ethnic minority community groups tackling inequalities in health and representing minority interests. Allow for on-going participation and consultation with ethnic communities in the implementation of the strategy and the planning development and design of health service provision.

In practice, implementing culturally competent health care provision would become an essential element within the community nursing service appropriate enabling preventative care and health promotion for all, including ethnic minority and immigrant communities (ERHA 2004, An Bórd Altranais 2005, HSE 2008). However, it is questionable to what degree community nursing services have been explicitly resourced to achieve the relevant actions set out in the strategy.

Experience of Irish Travellers

For decades the Irish health system has had particular experience in health service provision to Irish Travellers, resulting in the development of cultural competence within this sector. As an indigenous minority, Irish Travellers have self-identified as an ethnic minority group for generations with their own shared history, value system, customs, language and traditions. In the 1980s a national Traveller health study revealed significant health care disparities between Travellers and the settled Irish population. More recent research indicates they have continued to experience above average levels of ill-health and health care disparities, including higher rates of infant mortality, reduced life expectancy of adult males and females and above average levels of male suicide (Department of Health and Children and UCD 2010). In addition, Travellers as an ethnic minority continue to experience the negative social and health effects associated with marginalization and discrimination, demonstrating

the multilayered complexity of the interplay between socio-cultural factors influencing health outcomes (Tovey et al 2003).

In 2002, '*Traveller Health A National Health Strategy*' (Government of Ireland 2002) recommended healthcare staff receive appropriate in-service training on matters related to Traveller culture and societal attitudes in a bid to foster an awareness of the need to establish culturally appropriate health strategies. In recent years, many of the efforts to address health care issues with Travellers, employed community development and cultural competence models of health and wellbeing within the primary care environment. Indeed, it is suggested that shared learning opportunities and intercultural engagement between Travellers and newly arrived ethnic minority groups can mutually benefit both groups in the context of equality of access and non-discrimination in health service provision (HSE 2008, Pavee Point 2009, UCD 2010).

There is much to be learned from the research and literature on Irish Traveller health experiences and subsequent response from health services. However, due to the limited scope, the primary focus of this research concerns the transcultural experiences of nurses in the context of newly emerging immigrant ethnic minority communities.

Responding to Global Health

In a more culturally diverse Irish society, our interpretations and understandings of health and health care and how it is provided, require further exploration if we are to offer care that is valuable, effective and appropriate to all. An understanding by health care professionals of the concepts of health, as influenced by culture and other factors such as migration, is important in the delivery of public health nursing. However, of equal importance for nurses is an understanding of the concept of culture and its influence and impact on health and health care outcomes. While being cognisant of cultural similarities, some authors acknowledge that the concepts of health and health need are uniquely shaped by cultural experiences and in most cases are likely to differ from group to group (Galanti 2004, Helman 2007). Therefore, the development of cultural competence within a community nursing context requires attention to the broader global health agenda and the social determinants of health that influence and

affect the provision of care. As a service, public health nursing in the HSE is a relative newcomer in the area of responding to health care issues that derive from a more globalised and culturally diverse context.

For example, working with individuals and communities from culturally and linguistically diverse backgrounds, who have varying beliefs and understandings about health and illness, may prove particularly challenging for some nurses. Similarly, working with clients who have had life-changing experiences prior to arrival in Ireland, such as coming from a war-torn conflict area or experiencing torture or human trafficking may be outside the skill set of some nurses. In such circumstances, apart from requiring specific transcultural nursing resources and preparation, what is also required is an overall and standardised organisational approach, to resource and support such work. It is useful to look towards the experiences recorded in other countries and jurisdictions in this regard.

An example of efforts to assist with this are noted in the Cultural Linguistic Appropriate Services (CLAS) Standards, developed in 2000, by the US Federal Office of Minority Health. This national policy addressed a comprehensive series of recommendations that inform, guide, and facilitate practices related to culturally and linguistically appropriate health services (Office of Minority Health 2001). Similarly, based on research, specific guidelines for health care professionals caring for trafficked persons have been developed in the UK (Zimmerman and Borland 2009).

The CLAS standards also qualify the professional and ethical obligations of health care staff and organisations towards the implementation of safe and appropriate care. In addition, the legal and accreditation requirements outlined in the document, add further weight to the importance of staff preparation and on-going education and skills acquisition in cultural competence for health and social care professionals.

Interestingly, the CLAS standards have recently undergone a significant review and were further developed in 2013. This was mostly in response to increasing health and health care disparities and changing demographics (Office of Minority Health 2013). Such an approach demonstrates an understanding of the dynamic and fluid nature of global health issues and of the need to respond appropriately by reviewing approaches

to care. For example, in the 2000 CLAS Standards, culture was simply defined in terms of racial, ethnic and linguistic groups. However, following the review, the standards now define culture in terms of racial, ethnic and linguistic groups, including geographical, religious, spiritual, biological, and sociological characteristics. Similarly, the 2000 standards defined health as implicit; however, the 2013 standards contain an explicit definition of health that includes physical, mental, social and spiritual wellbeing (Office of Minority Health 2013). Consequently, this demonstrates an example of policy makers and professionals valuing the experiences of all stakeholders and responding to need and change in social health issues and also highlights the importance of reflection and evaluation over time.

It is clear that the CLAS standards offer guidance to individuals and organisations that are intended to advance health equity, improve quality, and help eliminate health care disparities. What is also evident is the need for practitioners and policy makers to revisit approaches, to ensure continuous improvement and accountability. An essential component of implementing such standards is attention to governance, leadership and workforce planning. In the context of this study, the CLAS standards provide a useful insight and structure for informing a strategic approach to the development of culturally competent community nursing services. I would also contend that, based on my own experience within the HSE community nursing service, the appropriate level of expertise and leadership skill is present. However, what is required is commitment from the whole organisation and there is a need for empirical evidence to assist in implementing appropriate change in response to the health care needs of culturally diverse communities.

Humans are mentally equipped to differentiate between individuals and groups (Bhopal 2007) and tend to focus on difference when outlining their experiences of working in a culturally diverse community. While this in itself is understandable and does not always present a conscious intent to exclude people, a disproportionate emphasis on difference within narrowly defined understandings of culture and ethnicity¹⁰ can emerge. This can negatively affect access and provision of care for

¹⁰ The definition of ethnicity used in the context of this local study is derived from the HSE Intercultural Health Strategy (NIHS) where ethnicity is defined as:

“...the shared characteristics of culture, language, religion, and traditions that contribute to a persons or groups identity. Ethnicity has been described as residing in: the belief by members of a social group

people of cultural, linguistic and ethnic minorities (Gerrish 2001, Culley 2006). Significantly, it can also result in health care professionals being less inclined to consider other cultural influences, such as diversity of social background, age, gender, and education across cultural groups (Kai et al 2007, Tilki et al 2007).

Although in itself migration does not necessarily pose a risk to health, circumstances surrounding the migration process may increase vulnerability to ill health, such as pre-migration experiences, access to health care, poverty, mode and circumstances of migration (Helman 2007, IOM 2009, Pace 2010, Gushulak et al 2011).

The complexity of the transcultural migrant health encounter requires attention, not just to physical and/or psychological pre-migration health effects but also consideration of the impact of post migration health effects, such as culture shock, acculturation and the integration process (Berry 2002, Podda-Connor 2007).

Bhopal (2007) suggests that in undertaking health needs assessments in multicultural societies, we need to have a clear definition of what health needs means. In exploring the concept of health, he refers to the generally agreed but sometimes derided WHO definition, that health is not merely the absence of disease or disability but a state of complete physical, mental and social wellbeing. He further suggests that this definition fails to consider other elements, such as spiritual and cultural dimensions that many individuals and communities value in defining and understanding their own health and their health needs. This is particularly true in many ethnic minority communities, as acknowledged by WHO (2010), when exploring health inequalities linked to migration and ethnicity. In addition, as a means of enabling and empowering multidisciplinary health care staff to respond appropriately to health care encounters in a culturally diverse society, an understanding of how culture influences health and healthcare outcomes is essential (Leininger 1995, Helman 2007, de Zuleta 2011).

Countries with well established patterns of mass immigration (destination countries) such as the United Kingdom, USA, Canada and Australia have been responding to the needs of migrants and minority ethnic service users for decades (Gerrish 1999,

that they are culturally distinctive and different to outsiders. Their willingness to find symbolic markers of that difference (food habits, religion, forms of dress, language) and to emphasise their significance. Their willingness to organise relationships with outsiders so that a kind of 'group boundary' is preserved and reproduced." (Tovey and Share 2003).

Zimmerman et al 2011). Notwithstanding the fact that the circumstances of immigration are multifaceted and unique to the social and geographical context, lessons can be learned from these international experiences. However, this is not to say that the experiences of all immigrants to these established destination countries has resulted in more positive experiences of social integration or better health care outcomes (Tilki 1998, Papadopoulos et al 2003). Nonetheless, it is accepted that the globalisation of health care has truly been established and nurses are required to respond (Davidson et al 2003).

Some of the barriers that people from minority cultural groups and migrants may encounter when attempting to access health services in their host country include, racism, no facilities for communication, insecure or poor accommodation standards, risks of poverty, negative mental health, and fear of officialdom – including health care professionals (Toar et al 2009, Aspinall and Waters 2010, McCartney 2010, Zimmerman et al 2011). Furthermore, understandings of concepts such as culture and ethnicity can become complicated due to them being pathologised or medicalised where interpretations within the work environment are not immune from the politicised and racialized constructions that occur generally in society (Ahmad 2007, Bhopal 2007).

To ensure an appropriate, practical response to the health needs of ethnic minorities and culturally diverse groups, the WHO outlines the importance for health care professionals and services in having knowledge of migration and concepts such as culture and ethnicity (WHO 2010). Similarly, the International Council of Nurses have produced position statements for nurses outlining their professional obligations in the treatment of migrants, refugees and displaced people (ICN 2008).

Consequently, in the context of this research study, some people living in local health service areas such as Liffeside may experience varying degrees of inequality in health care provision and a denial of fundamental rights when accessing or using health care services, including asylum seekers, refugees, illegal or undocumented immigrants (ICI 2011, Pace 2010, FLAC 2010). This may also be due, in part, to a combination of other more subtle barriers, including personal and professional ways of working.

For example, in the early 2000's, maternity care demographics were noticeably changing. In particular, increased maternity cases coinciding with increased asylum applications, were receiving significant (negative) media and political attention. This resulted in increased hostility towards and stereotyping of, female African immigrants as (Kennedy and Murphy-Lawless 2001).

In a study of maternity services in the Dublin area, Lyons et al (2008) revealed that some racist and discriminatory attitudes from staff within the maternity services did exist. This concurred with findings in maternity services in other jurisdictions (Cross-Sudworth 2007) and confirms that the racialising and stereotyping of immigrants in Ireland was occurring as described by Lentin and Mc Veigh (2002) and Fanning and Mutwarasibo (2007). However, during the period referred to above, it has been observed that there exists an obvious gap in scientific research from the Irish nursing and/or health service professions, specifically investigating racism as a form of discrimination (Markey et al 2012).

Some commentators have observed that racism is seldom mentioned in the nursing literature (McGee 1999). Other commentators acknowledge that narrowly applied concepts of culture tend to depoliticize discussions on race and other social factors relevant to health and wellbeing (Culley 2006). Gustafson (2005), who cites VanDijk (1993), suggests that prejudices such as racism are considered undesirable and that expressions and denials of racism evolve from their own discursive white etiquette, a result of which is the avoidance of provocative talk about race and racism.

Mc Gee (2009) further elaborates on the importance of acknowledging and working effectively with diversity and observes that focusing on difference requires individual motivation, reflection and organisational change. This is significant for two reasons. Firstly, for professional development, in keeping with acceptable ethical standards, for nurses and the nursing profession. Secondly, for the provision of safe equitable health care to the public.

In working with any client (individual or group), health care staff are obliged to consider the wider social determinants that influence a persons' health and wellbeing. Consequently, when working with immigrants, staff ought to be aware of particular influences that determine their health and their access to suitable treatment. In the

main, Irish community nursing is provided to people based on individual care needs rather than on any administrative category, i.e. citizen or non-citizen (An Bórd Altranais 2005, Nic Philbin 2010). However, as Ireland continues to experience an economic recession and the public health sector continues to face cuts, it is not beyond the bounds of possibility to that such conditions may change.

Already, from my own experience, I have noted the precarious health care position occupied by some categories of migrants. Examples include categories such as undocumented migrants or asylum seekers who have chosen to leave the statutory accommodation system (Direct Provision) and who do not ordinarily have access to continued primary care services such as GPs. Similarly, points of entry to health care that require payment such as A/E charges in hospital casualty, militate against the maintenance of health and wellbeing for the more vulnerable people in society. This is of particular concern in the context of public health, as continued community care is becoming increasingly dependent on people having access to a medical card or means of payment.

Furthermore, in such circumstances, what is called into question for health care workers, administrators and managers is the interpretation of government decisions, understandings of existing policies and their subsequent professional and/or personal attitudes and applications. If so, this could negatively affect the health and wellbeing of more vulnerable people such as migrants or ethnic minority groups and could compromise the ethical responses of health care staff (Boyle et al 2008, Mc Cartney 2010).

However, there remains a lack of research-based evidence to support this assumption. Within the HSE and nursing discipline little is known about how health care professionals, such as community nurses, specifically understand and respond to these types of transcultural health care situations. An exploratory assessment of cultural competence as suggested by this study may help to identify gaps and provide opportunities for further research and professional development.

Barriers to progress

Despite well intentioned efforts and developments in publishing policies for intercultural health care provision, there remains a significant gap and a major impediment to progression. The public health services in Ireland (Health Service Executive) have no uniform national system for gathering health intelligence data on race / or ethnicity, nor are they required to do so. This differs significantly from other jurisdictions such as the UK, where public bodies, including health services, must comply with certain conditions of the Race Relations Act (2000), by reporting on annual targets and outcomes that address racial equality and access issues within their services.

The lack of a consistent scientific mechanism to record national ethnic data within the Irish health system raises some fundamental questions as to how services are planned, funded and targeted. In the absence of such information, recognition and prevention of health care inequalities or discrimination occurring in clinical practice and service provision at local or national level will prove difficult to confirm (HSE 2008a, Karl-Trummer 2010). In addition, supporting health care staff to deliver culturally competent care will remain challenging in the absence of such data. Proceeding with such interventions requires careful planning and sensitivity. Ethnic monitoring and data collection in health care does not provide a panacea for ensuring culturally appropriate care or diversity management within health services but may assist towards such goals (Esmail 2005).

Although the collection and analysis of ethnic data is sometimes considered useful in epidemiological health care planning, Bhopal (2007) cautions us on the value of its use in certain circumstances. For example, he notes the often limited use of ‘administrative’ categories, such as those used in census surveys that rarely account for inter-ethnic variables such as physical (mixed ethnicity) or social (socio economic / class) variations. If ethnic monitoring data is collected and available, it must be used ethically and sensitively and not result in social harm. Bhopal (2007) cautions health care researchers and organisations on this issue:

“Research focusing on problems more common in minority groups, combined with data presentation techniques designed to highlight differences in comparison to the majority population, so easily portrays the minorities as

weaker.....differences due to the environment are sometimes perceived as transitory and therefore unimportant, indeed possibly even unrelated to race or ethnicity, while biological differences are quite wrongly seen as effectively permanent and fundamental to race and ethnicity....” (2007, p.9)

He also draws attention to the existence of ethnocentrism, i.e., the inherent tendency to view one's culture as superior and the standard against which all others are judged. He claims that ethnocentrism may be one of the possible reasons for the lack of emphasis on the value of ethnicity and health studies for service development. If ethnocentrism exists, it will most likely affect the design, aims and methods of investigation, including the interpretation and presentation of results.

Although the scope of this study does not concern itself with investigating the causes of ethnic health care disparities, it is important to understand the implications of ethnocentrism in the context of delivering community nursing care.

Ethnocentrism and racism have a negative impact on the health of people from ethnic minority communities (Burgess et al 2007, Kai 2007). The experience of racism can have devastating effects within a community, contributing to further vulnerabilities and risks due to social isolation. In countries with established experience in transcultural health care provision, it is widely accepted that discrimination and harassment in everyday life affects people's health and wellbeing, including behaviours which may be damaging to health (Tilki 1998, Karlsen and Nazroo 2002). This has implications for the ways and the stages at which care is accessed and is linked to wider societal issues. To combat racism in healthcare and nursing, Tilki et al (2007) and Markey et al (2012) emphasise the importance of a structured and safe development process within a supportive environment, as a means of enabling health care organisations and staff to reflect on practices and discover solutions in collaboration with communities and service users. Naming and acknowledging racism as an explicit phenomenon is essential for addressing ways of combating it and for ensuring ethical and equitable care.

Indeed, representatives from minority ethnic communities in Ireland draw attention to the consequences for service users when cultural issues within service provision are misunderstood or misrepresented. Ethnic minority community representatives

consider it important for health services to acknowledge and attribute these responses to 'racism' rather than to organisational structural barriers (Cáirde 2006, HSE 2008, ICI 2011).

Acknowledging that the global recession has impacted significantly on domestic, social and economic developments, some commentators have observed and highlighted an apathy and lack of political leadership in progressing interculturalism and integration, including efforts to combat racism in recent times (Fanning 2011, Mutwarasibo 2012). This has also been remarked upon by the CERD Committee of United Nations General Assembly in December 2011, as part of the Human Rights Council Universal Periodic Review of Ireland's status. Concerns were raised by the Committee about how government budget cuts were disproportionately affecting efforts to combat racism and they recommended a review of the National Action Plan Against Racism. (NGO National Alliance Against Racism 2011).

Moving forward into the health care context, the continuous commitment to the implementation of these policies cannot be overemphasised. There is no room for complacency when it comes to the responses of health care staff and organisations in ensuring the delivery of equitable services within the stipulated legal and ethical requirements. However, within the public policy arena it is widely accepted there are conflicting impediments for public organisations when implementing agreed policies. The difficulties translating such policies into practice are affected by many social political and economic factors. Fotaki (2010) suggests that within the process of designing and applying public social policy, a powerful subjective social fantasy emerges within many organisations, limiting the tangible results that should accrue from such policies.

It is unlikely that all of the actions and recommendations for delivery mentioned in the HSE National Intercultural Health Strategy (NIHS) will be achieved within the time frame (2007-2012) for implementation. In addition, no intermediate audit or review of the NIHS Strategy had been undertaken during its lifetime, primarily due to cost implications (HSE 2012a).

Consequently, what is required within health care organisations is a new way of ‘doing’ leadership, in order to avoid any complacency or ineffective outcomes that that may evolve (Zaleznik 1998, Alimo-Metcalfe & Alban-Metcalfe 2005).

The UNESCO Universal Declaration on Cultural Diversity (2001) raised the level of cultural diversity. It was now to be understood as the common heritage of our humanity and to be as necessary for humankind as biodiversity is for nature, making its defence an ethical imperative, indissociable from respect for the dignity of each individual.

Therefore, it is clear that the application of these national and international instruments is relevant to the provision of health care and nursing. However, policies alone do not necessarily transfer into actions for positive change.

Cultural Competence & Transcultural Nursing

A number of commentators suggest that nurses need to become more alert to the broader socio-political contexts of the health care environment (Duffy 2001, Gustafson 2005, Culley 2006). By becoming more critically aware of the complexities and influences that inform transcultural experiences, nurses can become more empowered in themselves, their practice and the communities where they work. Encountering the many forms of diversity within the global human experience can be challenging and may be further compounded when operating within another sub-culture such as nursing or healthcare (Mc Gee 2009).

The terminology and language used to describe cultural competence and transcultural care¹¹ in nursing and healthcare varies widely. This is illustrated by the many definitions that exist around the topic in the literature (Douglas & Pacquaio 2010). These terms are sometimes narrowly misunderstood as exclusively focusing on cultural practices that are perceived to adversely affect people’s health and wellbeing. Frequently within the literature, terms such as culturally appropriate, cultural

¹¹ For this study both terms ‘cultural competence’ and ‘transcultural care/nursing’ are used interchangeably when referring to the community nursing context, in order to represent a more complete understanding of the requirements in caring appropriately for people from different cultures and in the provision of services.

sensitivity, cultural safety and cultural awareness are used interchangeably by authors and may be recognised as distinct definitions by others. Of particular significance in this regard is an awareness and understanding of the historical, social, political, cultural and geographical influences that inform its construction and application, including the use of language. Therefore, in the context of this study, it is important to consider the context of cultural competence and how it is socially constructed.

To date I have observed limited evidence of formal planned transcultural nursing strategies aimed at promoting and establishing cultural competence in public health nursing in the Health Service Executive. Although some efforts have been made to address the importance of intercultural education in health care and transcultural nursing within a general European context (Taylor 2011), there remains a lack of action and research in this area in community nursing in Ireland. This view is partially supported by the dearth of published empirical transcultural research emanating from the Irish nursing discipline with regard to cultural competence practice or education (Tuohy 2008, Lyons et al 2008, Markey et al 2012).

In considering the development of cultural competence, the experience of nursing in Ireland has differed significantly from other Westernised English speaking countries such as the United Kingdom or United States of America. For example, up until the late 1990s, the monocultural demographic of the Irish population and sustained levels of mass emigration significantly impacted and influenced Irish nursing.

On the other hand, through the sustained immigration of mobile populations from former British colonies over many generations, the UK has developed a significant culturally diverse population. Consequently this created a socio-political context and led to the development of policies and strategies of social inclusion by catering for cultural diversity in service provision in the context of addressing equality and non-discrimination. However, many changes came about because of evidence of health care disparities within minority communities in the UK and community action led to their being empowered to address such inequalities (Bhopal 2007). The impact of immigration on local community health services required investigation of the development of cultural competence and transcultural staff preparation.

For example, in the United Kingdom, the Royal College of Nursing provides educational resources, including theoretical and practical instruction on transcultural nursing and culturally competent health care, to nurses entering the profession, specifically as part of their continuing professional development (RCN 2004).

In addition, in keeping with ethical and professional development standards, specialist transcultural health research centres provide opportunities to staff, organisations and management (Papadopoulos 2006). Notably, the American Association of Colleges of Nursing also encourage nurses to become educated in cultural competence (AACN 2010), and in countries with an established history of immigration and indigenous minority ethnic groups, such as Canada and New Zealand, transcultural nursing knowledge and cultural competence is considered a professional and legal requirement for practice (Ontario College of Nursing 2009). Similarly, in the USA, in the general context of health care provision, organisations must provide mandatory training in cultural competence to their staff.

In their pioneering work on developing a culturally competent system of health and social care in the USA, Cross et al (1989), described cultural competence as a set of congruent behaviours, attitudes and policies that come together in a system, agency or professional to work effectively in cross-cultural situations.

In considering a culturally competent system of care, Cross et al (1989) suggest that an organisation must acknowledge and incorporate, at all levels, the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural difference, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs. By describing cultural competence as both a process and a skill based phenomenon that is fluid and dynamic, Cross et al (1989) acknowledged that an individual's or organisation's level of cultural competence is not fixed along any particular point.

To better understand cultural competence as a process, the authors propose that it is useful to think of the possible ways that people, organisations and professionals respond to cultural differences. Therefore, they developed a cultural competence continuum model that ranges from cultural proficiency to cultural destructiveness,

explaining within each the characteristics that may be exhibited, with a variety of possibilities between these two extremes:

- Cultural destructiveness;
- Cultural Incapacity;
- Cultural Blindness;
- Cultural Pre-competence;
- Cultural Competence;
- Cultural Proficiency.

In proposing such a model the authors accept that planning must be approached within a developmental understanding of the acquisition of cultural competence. In so doing, they acknowledge that professionals or organisations will each reach different points along the continuum within different timelines. Thus, cultural competence can develop at its own pace within the context of experience and meaning for that person or organisation.

In the discipline of nursing, Leininger (1995) observed that nursing practice appeared to lack attention to cultural and humanistic factors, claiming it was operating from a medicalised quantitative paradigm. Using qualitative methods as an anthropologist she developed a transcultural nursing theory titled ‘Culture Care Diversity and Universality’ (Leininger 1995). The definition of transcultural nursing put forward by Leininger is as follows:

“Transcultural nursing is a substantive area of study and practice focused on comparative cultural care (caring) values, beliefs, and practices of individuals or groups of similar or different cultures with the goal of providing culture-specific and universal nursing care practices in promoting health or wellbeing or to help people to face unfavourable human conditions, illness or death in a culturally meaningful way” (1995 p.58).

This definition acknowledges that nursing is itself a culture, with culturally defining modes of functioning e.g., language, terminology, behaviours, practices, knowledge, values, meanings, which can change over time due to developments and influences inside and outside the discipline. Examples can be found in science and technology, social or political changes, professional or legislative changes. By developing such a theory, Leininger explains the purpose was to:

“...describe, explain, interpret and predict phenomena related to human care and culture in order to identify and document specific care knowledge that would fit and be acceptable to the people nurses served” (1995 p.97).

In many respects to provide culturally competent care within a community nursing context is to provide ethical care to all people (Leininger 1995, Papadopoulos 2006) where clients are considered true partners to enable the development of trust, acceptance and respect including facilitation and negotiation. Therefore to be culturally competent requires empathy and humility (Leininger 1995, Beach et al 2006).

However while the theoretical origins of transcultural nursing have evolved over time (Douglas and Pacquaio 2010), it is sometimes viewed as having a narrowly defined application and continues to be challenged and evaluated by other health care theorists in consideration of the broader context and understandings of social change in health care provision, health care systems and culturally competent organisations. (Gustafson 2005, Culley 2006).

In addition to epidemiological and clinical knowledge, a social and anthropological understanding is required. Cultural competence in health care involves an understanding of the complexity of relationship between culture and health and/or illness within the socio-political community context and how this relationship affects the manifestation of illness, health seeking behaviour, access to types of care and communication (Cross et al 1989, Helman 2007, Office of Minority Health 2013).

In considering knowledge and learning from both transcultural nursing and cultural competence in health care, Papadopoulos (2006) describes transcultural care as being underpinned by a philosophical theoretical paradigm emerging from an amalgam of scientific and philosophical disciplines including sociology, psychology, medicine, nursing, anthropology and politics.

Cultural competence in health and social care as described by Papadopoulos (2006) reflect the meanings and interpretations of transcultural care:

“.....the capacity to provide effective health care taking into consideration people’s cultural beliefs, behaviours and needs.....cultural competence is both a process and an output and results from the synthesis of knowledge and skills which we acquire during our personal and professional lives and to which we are constantly adding....” (2006, p.10)

A culturally competent transcultural nursing approach will require a shift from a problem or disease focused clinical care perspective, include lived experience perspectives, i.e. an approach that is patient-centred with attention to community aspects that people feel connected to and part of. Health care staff needs to consider cultural factors impacting on individual clients and recognise that intra-cultural variations exist amongst and between all cultural groups.

Some writers in transcultural healthcare acknowledge that cultural competence for both service users and providers is derived from, and applied within, a shared experience and understanding of empowerment (Cross et al 1989, Purnell and Paulanka 2003).

In their work on developing culturally competent systems of care, Cross et al (1989) recognise the importance of working in conjunction with natural informal support and helping networks within minority communities including neighbourhood representative groups, community based leaders / organisations, churches, etc. In considering this collaborative approach, Cross et al (1989) acknowledge the broader socio-political aspects of cultural competence that extend the concept of self-determination to the community. This implies an understanding by healthcare professionals, organisations and healthcare systems that only when a community recognizes and owns a problem, does it take responsibility for creating solutions that fit the context of the culture.

Furthermore, Seright (2007), in writing about cultural competence in nursing, cautions us of the dangers of narrow understandings and applications of cultural competence.

Ignoring the diversity that exists within and between cultures and cultural groups, or applying narrow definitions of cultural competence can lead to stereotyping and ineffective health care provision. Drawing on the work of anthropologist De Santis (1994), Seright (2007) observes that;

“...nurses who are able to operate from a perspective of cultural competence will rapidly learn that culture is a component of all human life, including health and illness, and not something that mainly affects persons who are ethnically, racially or socio-economically different from them....”

(2007, p.47)

Similarly, Beach et al (2006), in a comprehensive research paper on the evolution of cultural competence and patient-centeredness in health care quality and practice, indicated it was no longer acceptable to consider ethnic minority or culturally diverse patients as passive medicalised entities with complaints stemming from bodily disease. There was a need to consider the possibility of an illness occurring within a biopsychosocial and cultural system of which the person was part, with an obligation on health care professionals to understand and respond. Klienman (1978), amongst others, had also encouraged this type of approach within medicine, looking at simplified models (explanatory models) for understanding people's own cultural interpretations of their health and illness including health seeking behaviour (Berlin and Fowkes 1983).

Subsequently, at a practical level health care providers and patients could have a meeting of minds and reach common ground for a safe, effective and mutually agreeable healthcare encounter. This would be achieved through the provider and client eliciting, explaining and negotiating understandings of illness and its perceived causes in a language accessible to patients. This process of critically questioning and deconstructing the Western biomedical perspective is considered central to effectively delivering care across cultural boundaries. An essential element in this deconstruction is communication.

Intercultural Communication

Implicit in Leininger's transcultural nursing theory is the importance of communication between the patient / client and the provider of care. It acknowledges that a lack of communication and a misunderstanding of what it means to care within a cultural context, will lead to a lack of respect and result in potential or real harm to the patient, whether culturally, psychologically, physically, or spiritually.

It is noted that people from minority cultural and language backgrounds face a disproportionate risk of experiencing preventable adverse events in comparison with

majority mainstream population groups (Johnstone and Kanitsaki 2006, Mac Farlane et al 2009). Cultural competence requires a level of inter and intra-personal awareness, knowledge and skill that enables effective communication and an appreciation for how language is used to relay lived human experiences, whether sick or well, within cultural contexts. Leininger (1995) states in her principles of cultural competence and transcultural nursing that:

“Cultures have the right to have their cultural care values, beliefs and practices respected and appropriately used in nursing and other health services...understanding and using the language of the people is extremely important in culture care.... [and] involves attention to verbal and non-verbal language in cultural context with meanings and symbols in order to have beneficial and therapeutic culture care outcomes” (1995, p. 83)

An essential requirement for ensuring this occurs is an understanding of the dynamics of power within the transcultural health care encounter and the ability to communicate and negotiate openly, honestly and respectfully to ensure a mutually beneficial healthcare outcome. The development of trusting and meaningful therapeutic relationships between care giver and patient is dependent on effective communication (Papadopoulos 2006, Beach et al 2006). In addition to best practice and professional ethical care, attention to the link between safety and cultural and linguistic factors needs to be considered as a legal requirement (Office of Minority Health 2004, Johnstone and Kanitsaki 2006, Council of Europe 2006, HSE 2009a).

The CLAS Standards of the Federal Office of Minority Health and Human Services in the USA (Office of Minority Health, 2013) stipulate the importance of linguistic competence for healthcare staff and organisations. The underpinning philosophy and intent of the CLAS Standards is to ensure that health services and staff maintain and provide equity in service provision by preserving dignity and quality care for all. Effective inter-cultural communication is a key principle in aiming to achieve cultural competence. In the absence of specific communications supports there is a risk of compromising the quality of care provided. For community nurses this could have significant implications for practice, while also having negative affects on health care outcomes for ethnic minority service users.

However, standards vary across the universal healthcare sector and, in reality, the experiences of ethnic minority service users with limited English proficiency or who

speaking another language, indicate significant room for improvement. Cultural misinformation, cultural misunderstandings or cultural imposition as a result of poor communication methods can result in adverse and negative health care outcomes (Cohen 2005, Rosenberg et al 2007, Crossmann et al 2010). In addition, a lack of knowledge and awareness by health staff of aspects of verbal communication, such as the paralinguistic components of language and vocal conversation, can also lead to tension and misinterpretations if not properly understood in the context of intercultural communication.

Similarly, in Ireland a limited number of studies, pertaining to health care staff and services, indicate that where interpreting and translation services are available the level of uptake is inadequate and not in keeping with best transcultural practice. Of particular concern is the lack of appropriate training, absence of quality control, and in some instances, a low awareness by the public of their right to an interpreter (NCCRI 2008, Mc Farlane and de Brún 2008). However, it must be acknowledged that intercultural communication concerns more than language and is a multifaceted and complex phenomenon. The provision of interpreting or translation services is not enough in itself but requires education, training and continuing evaluation in the context of cultural mediation and cultural interpretations (Robinson and Philips 2003, Mc Farlane et al 2009).

Nursing in the Community

In recent years community nursing has changed in response to globalisation, technological advances, and developments in professional research including educational preparation and legislative regulatory standards (Davidson et al 2003, NMPDU 2006, Brady 2007, Nic Philbin 2010, ONMSD 2012). However, in the HSE, community nurses continue to face the challenges of cultural diversity and are rarely provided with practical opportunities to consider theoretical and practical approaches in the delivery of transcultural care.

Within the HSE community nursing context, there is significant room to develop such an approach, using cultural competence models when working with culturally diverse communities. Public health nursing in Ireland has traditionally been a service offered to communities over the life-span of care, sometimes referred to as a 'cradle to grave'

nursing service. As population demographics change in response to globalisation, public health nurses require the skills and knowledge to deliver appropriate care to communities made up of immigrants and people of ethnic minorities of all ages and backgrounds (CSO 2007, CSO 2011). However, before considering transcultural nursing approaches there is perhaps a need to rethink the meaning of community nursing and its place in community health care.

Baisch (2009) has identified a number of issues that are relevant to nurses in response to a changing community health context. He suggests that an increasing number of community health professionals practice without a clearly defined and universally accepted meaning of the concept of community health. She acknowledges that the concept of community health is an interdisciplinary phenomenon that sometimes leads to confusion, where surrogate terms and related concepts of community health such as community health, primary care, public health and population health are used interchangeably. For example, when professionals of different disciplines and community members collaborate in practice or on projects, the language they use to describe their work may differ. The meaning they give to the same terms may vary and approaches they use may be derived from different disciplinary models such as medicine, social work, nursing, paramedical, or health administration. In addition, confusion may exist because conceptually, community health includes the idea that each community defines its own health, a standpoint not always considered by health care professionals in the biomedical sphere. Each community's definition of health will be dynamic, varying with the temporal and socio-cultural context. Therefore, Baisch (2009) lays down a challenge for nurses to consider the underlying philosophy and professional theoretical context that they are working from. The challenge is for nurses to be active participants in the delivery of health care systems, in keeping with the theory of development of culturally competent health and health services, originally posited by Cross et al (1989). Self-determination and ownership by minority communities within the health care context is fundamental to effective health care outcomes and must be enabled by health care professionals and organisations.

An important element in working with transcultural health issues is gaining an understanding of the politics of the balance of power and representation that exists,

for and between, minority and majority stakeholders (Gerrish 1999, Gustafson 2005, Culley 2006). Very often, health care workers and professionals are not consciously aware of these socio-political or cultural factors and rarely consider or evaluate their impact on their practice or service delivery. Papadopolous (2006) reminds us that:

“Transcultural health and nursing emphasizes the importance of empowering clients to participate in health care decisions: therefore it is imperative that health professionals recognize how society constructs and perpetuates power and disadvantage” (2006, p.8).

The need for collaborative partnerships between service users, professionals and community based organisations is fundamental to developing cultural competence and community nursing. Others have considered social justice as a core principle of transcultural nursing, to be considered in the practice and provision of nursing care (Pacquaio 2008, Clingerman 2011).

Baisch (2009) suggests that the evolution of the concept of community health reflects a paradigm shift in health care away from professional control and a move towards community leadership and empowerment. Nurses and other professionals in the community setting must support their community partners to ensure that ownership of community health planning and implementation of services is derived from the community to meet its own needs.

Community development models that identify social, economic, environmental and cultural factors influencing health and health outcomes are compatible with community nursing approaches. Some of the key principles of community development such as empowerment, participation, commitment to equality and shared ownership complement the philosophies of transcultural and community nursing (An Bórd Altranais 2005, Clarke 2004, Nic Philibin 2010, ONMSD 2012). These can be used as a means of strengthening and building healthier communities and contribute to health service design, planning and delivery (Cáirde 2006, Baisch 2009). These are approaches that nurses should not shy away from but should be empowered to consider in their practice when providing care in the community.

A Critique of Cultural Competence

MacLachlan (2006) has criticised some professional cultures for the conservatism and self-interest that militates against recognition of the pluralism required for health care systems that adequately serve culturally diverse populations. As many individual and organisational factors can impact on its application, cultural competence as a complex process can be difficult to apply, making effective outcomes difficult to measure at times. Therefore, a tendency to view cultural competence as reductionist, simplistic and based on a finite body of knowledge can sometimes prevail. While some scientific and academic discourses continue to question its value (MacDonald et al 2007); others consider its benefits and contribution towards more inclusive health care provision and reduced levels of health care disparities (Betancourt et al 2002, Papadopoulos 2006, Bhopal 2007, Office of Minority Health 2013).

In a critical review of transcultural nursing, Gustafson (2005) draws attention to the development of ethnocentrism centred on individual behaviour rather than on systemic practices. She cautions against the assumption that a primary influence on the development of an individual's racism in nursing can be attributed to a 'lack of knowledge', giving rise to fear and mistrust of 'the Other'. Modes of thinking around the construction of 'the Other' (e.g. foreign trained nurse, immigrant) and the perceived threat posed by them, advances an us/them / inferior/superior dynamic, typical of a racializing discourse. The resulting consequences of this are bias, discrimination and prejudice, mostly situated in the individual psyche, and linked to essentialist racism that believes that people of colour are fundamentally 'Other' than white people.

Reflecting on my own personal and professional experience, in my overseas development work and in the earlier years of my current post, I can now recognise that at times I, consciously and unconsciously, engaged in ethnocentrism and cultural imposition. Why was this so? Perhaps in hindsight I was blind to my own cultural awareness and the development of my own cultural sensitivity; mostly as a consequence of the mono-cultural experience of living in Ireland up to the late 1990s. In addition, the fact that I had experienced myself as the 'other' has provoked a curiosity and interest in further exploring my own identity and examining how

identities are constructed, understood and valued in society, particularly in health care and nursing.

Gustafson (2005) suggests that this promotion of individualised responsibility is not seen as interconnected or politicised but as distinct, bounded static biological categories of human identities. Consequently, she suggests that rather than a lack of knowledge being the issue, it is due to dominant discourses of superiority and privilege. These are marked by a lack of challenge to those social, political and ideological constructs that exist in the human experience of living that continue to exacerbate inequality and discriminatory care. Similarly, Duffy (2001), in a critique of cultural education in nursing, refers to multiculturalism increasing the distance between cultures because of its celebration of the superficial and its failure to address underlying social conditions such as acceptance and integration. Duffy concludes that professional healthcare education and research requires a re-thinking and emphasis on equality and inclusiveness.

In the globalised healthcare context, there is a danger that researching the real impact of the social determinants of health, as experienced by ethnic minority groups, will be considered uneconomical. Consequently, transcultural nursing issues and cultural competence may not be considered a professional organisational priority in healthcare systems planning. Such views must be continually challenged (Marmot and Wilkinson 1999, Marmot 2005, WHO 2010).

Other more subtle barriers at the health care practitioner level may include practices and attitudes that require large amounts of time or resources, interpreters for example. In addition, a lack of self-awareness or knowledge of socio-political sensitivities around issues such as ethnocentrism, equality, discrimination, and / or human rights may impact on how health care workers view and consider minority ethnic clients presenting for care. For example, sensationalist and negative media portrayal of cultural diversity or transcultural issues may inadvertently influence some health care professionals' actions or attitudes (Lyons 2008,). Currently, in some European countries, access to medical services for non-EU citizens is severely curtailed. This

raises fundamental ethical questions for health care staff who may feel coerced into unfavourable and discriminatory health care practices (Pace 2010).

Culturally competent health care and transcultural nursing can be a rewarding and empowering discipline. It can also be personally and professionally challenging, exposing staff to complex and sensitive social realities that often conflict with learned and closely held values and beliefs (Leininger 1995). Other researchers have observed that psychological, social, and professional factors may, consciously or unconsciously, influence organisational and individual responses to difficult emotional work-related issues in health care settings (Menzies 1960, Smith 2002, Gabriel 2010).

For example, within the nursing profession Gray and Smith (2009) have researched the positive and negative aspects of emotional labour and the impact of this on staff, patients and relatives. In considering the work of Hochschild (1983), who describes emotional labour as ‘the induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial, safe place’, Smith and others acknowledge that emotional labour is tacit and often unspoken, rarely officially supported or facilitated by management, yet it enables care and service provision to function and be maintained.

Although conflicts such as emotional dissonance can arise stretching nurses to breaking point or burnout – nurses are, typically, very much aware of the high therapeutic value of emotional labour approaches. Emotional labour and cultural competence development are closely connected, as both require reflection on attitudes, behaviours, actions and motivation within the delivery of health care. Interestingly, Gray and Smith (2009) acknowledge the need for further research on the emotional aspects of cultural beliefs, due to cultural differences and divergences that can exist within global health care systems. Other writers and researchers (Culley 2006, Tilki et al 2007, Markey et al 2012) have explored where these types of tensions become evident in nursing practice, manifesting themselves as ignorance, self-preservation or disinterest in the attitudes and behaviours of staff and services.

It must also be acknowledged that staff may not be provided with opportunities to sensitively explore challenging work issues. In general, this may be due to lack of leadership expertise from management, who may themselves have limited knowledge and /or awareness of their vulnerabilities as leaders (Heifitz 2002, Strack 2003). It could also be explained, specifically in health care, by a lack of opportunities for facilitated mentorship and reflection opportunities for staff. These could potentially allow for staff to discuss and plan informed and structured supports and resources for the appreciation of emotional labour in health care work.

In summary, although drawing mostly from nursing and health care literature, the complexity and multifaceted nature of cultural competence required consultation with a broad range of literature. It was intended that this approach would enable a better understanding of the significance of the socio-political theoretical aspects, including the educational methodologies, which underpin culturally competent practice. Consequently, this approach to the literature enabled a more critically informed overview of the literature and helped to inform the research design for this study. These will be outlined in the following chapter.

Chapter Three: Methodology and Project Design

Choosing a Methodology

As I wanted to explore how participants make sense of their personal and social world and the meanings associated with particular experiences, I felt a qualitative interpretative methodology was appropriate to this study. I was cognisant of the ‘three Ps’ referred to by Brannen (2005), *paradigms*, *pragmatics* and *politics*, and while I was aware that all or any one of these may influence the researchers’ rationale for their chosen method, I chose this approach because of its focus on meaning in particular contexts among people who share a particular experience. This approach initially presented possibilities because it focuses on the essence of an experience and on the common structures of experience. It attempts to explore phenomena in a manner, which as far as possible, facilitates the expression of that experience in its own terms as opposed to the use of predefined categories.

The philosophical assumptions underpinning my choice of design and methodology emerged from my own personal and professional experiences, motivations and interests. Van Manen (2007), in describing phenomenological qualitative research, describes its aim as gaining a deeper understanding of the nature or meaning of our everyday experience, or the search for what it means to be human, taking into account the socio-cultural and historical traditions that give meaning to our ways of being in the world. In other words, it has as its ultimate aim, the fulfilment of our human nature, i.e. to become more fully who we are (van Manen 2007).

Similarly, Smith and Osborn (2007) conclude that in an attempt to explore participants’ experiences, the interpretative phenomenological approach involves detailed examination of the participant’s ‘life world’, as part of a dynamic research process, allowing the researcher to develop and apply empathetic and critical interpretations.

Over the years, my nursing experience has allowed me to observe and experience many influences on people’s health and wellbeing, including the responses of professional staff and organisations. The time I spent in the developing world,

coupled with my further studies in the community development discipline, has enabled me to consider social, human, economic and political factors that I had not considered in my nursing practice; for example, access to resources, human rights and empowerment, poverty and social class (Marmot 2005, Ingleby 2010). The experience I have gained from my work with asylum seekers has resulted in a more conscious awareness of these influences and the development my own cultural competence. I consider this development process to be on-going, thus providing useful opportunities for reflecting on and challenging my own assumptions and impositions. I am interested in how these factors are considered (or not) in the delivery of care by community nurses in the context of an increasingly diverse cultural demographic. Consequently, these experiences resonate with my professional role and have influenced my chosen methodology.

My political position for this study locates me within a complex lived experience of nurse practitioner, researcher, colleague, human being, and citizen. In the context of this study, as a politicised researcher, I am also concerned about forms of knowledge, the linkage of knowledge and power, how power is constructed and by whom, and how it is utilised and disseminated in the provision of care for all.

Being mindful of the power dynamic inherent in the health service provider / user relationship, I am also aware of my own position and cognisant of how this may affect my relationships with participants in the research process. For example, my CNS role is officially a nursing management category and may impact on how participants view me or interact with me as a researcher. As a member of the national HSE Intercultural committee, I am also conscious of the inherent social fantasy (Fotaki 2010) within public organisational systems that can impede the practical application of care and conflict with professional decisions. In other words, based on my experience of working as a nurse at 'grass roots', I am familiar with how corporate organisational policy, although in existence, may not be operationally effective or even known to others at varying levels within an organisation. This is my current experience in the context of transcultural health care and is a motivating factor in conducting this research.

As the study primarily sought to generate an understanding at the micro level, the agency of the participants and indeed of myself as researcher was emphasised within subjective interpretations and perspectives. Although the pragmatic rationale of the study centres on the production of research findings and results that can enhance practice and policy development locally, it was anticipated that meanings and understandings interpreted within the human and relational context of nursing and health care would also emerge from the research.

Consequently, I acknowledge that as I attempted to get closer to the participants and derive meaning from their experiences, I assumed some level of an insider's perspective. This should be taken with the proviso that this perspective cannot be achieved directly or completely. Smith and Osborn (2007) suggest that access depends on, and is complicated by, the researcher's own conceptions, acknowledging that it is only through a process of interpretative activity that we can begin to make sense of that other world.

Silverman (2010) acknowledges that such subjective reality is important for the researcher in determining explanations and perhaps posing further questions. It has been suggested that by focusing on the subjective experience of study participants, it is possible to gain a deeper insight into human nature (Maggs-Rapport 2000) and that such experiences reveal the immediate, pre-reflective consciousness a person has regarding events in which one has participated (Klieman 2004). Unlike quantitative research with its focus predominantly described in terms of quantification, objectivity and generalisation; qualitative research aims to explore human behaviour and human experiences, thereby extrapolating description and meaning of an experience as it is lived and understood by the participants (Van Manen 2007, Smith and Osborn 2007, Silverman 2010).

Following discussions with my academic advisor and project supervisor, I felt my methodological approach was also in keeping with the philosophical and theoretical foundations for the development of cultural competence. In the context of promoting and undertaking culturally competent health care research Papadopoulos (2006) states:

“Research continues to exclude culture and it’s related concept of ethnicity as essential variables....[]....One reason for this has been the continuing domination of the health research agenda by positivistic approaches with a focus on objective measurement, emphasis on facts, prediction and production of value-free universal truths...[].....cultural competent research is reflexive research...it requires researchers to be conscious of and to make explicit their positions in the research process irrespective of their chosen research design...” (2006 p.85)

In this study I wished to explore the realities of transcultural care faced by community nurses, based on their work with culturally diverse clients, providing both a descriptive and interpretative account of these realities. Therefore, I chose this interpretative phenomenological approach because it allowed for the emergence and presentation of themes that I hoped would both reflect participants’ experiences and understandings and thus contribute to meaning and sense-making in the community nursing context.

As with all research methodologies, limitations exist. With a qualitative interpretative approach, the role of language and communication are fundamental. Phenomenological interpretative approaches work with texts and language and examine the ways in which participants try to communicate their experiences (Crotty, 1998, van Manen 2007, Smith and Osborn 2007, Silverman 2010). Consequently, there is a presumption that language provides participants with the tools to communicate their experiences. The uses of language for description and interpretation, in an attempt to achieve understanding and extrapolate meaning from the data, can differ. Questions are raised as to whether participants are able to adequately communicate their experience. For example, the language or words that people choose to use to describe their experience(s), also constructs a specific version of that experience and so the same phenomenon may be portrayed in different ways. Similarly, people may or may not be able to express or articulate the nuances and subtleties of the totality of their experience through language. These issues will be discussed later in the analysis.

In considering limitations of the methodology, issues of power and interpretation must also be taken into account. In particular, it is important to be aware of the possibility of the misuse of power by researchers, in order to avoid imposing meanings on

participants' accounts in an unreflective manner. Therefore, while qualitative researchers go beyond appearances in an effort to extrapolate understanding from that which is hidden, they should avoid imposing meaning on the phenomenon, editing it to fit categories and breaking it down to underlying causes. Indeed, such an undertaking requires a clear ethical position on the part of the researcher. This will be discussed later in the ethics section.

A criticism of the interpretative approach is that it makes no claims to objectivity and generalizability. However, Silverman (2010, p.150) in considering generalisation in qualitative research, cites Alasuutari (1995) who claims that;

“Generalisation is...[a] word ...that should be reserved for surveys only. What can be analysed instead is how the researcher demonstrates that the analysis relates to things beyond the material at hand... extrapolation better captures the typical procedure of qualitative research” (1995, p 156).

However, according to Van Manen (2007) and Smith and Osborn (2007), this approach does not offer us the possibility of effective theory with which we can explain and/or control the world but rather it offers the possibility of plausible insights that bring us more directly into contact with the world (Benner 1994).

In choosing an interpretative qualitative research methodology that has a theoretical commitment to the person, as a cognitive, linguistic, affective and physical being and that assumes a chain of connection between people's talk and their thinking and emotional state (Smith and Osborn 2007), I hoped to add to the existing research on cultural competence in health care which has been a neglected and understudied facet of community nursing in the HSE and Irish health service.

Papadopoulos Tilki Taylor (PTT) Model For Developing Cultural Competence

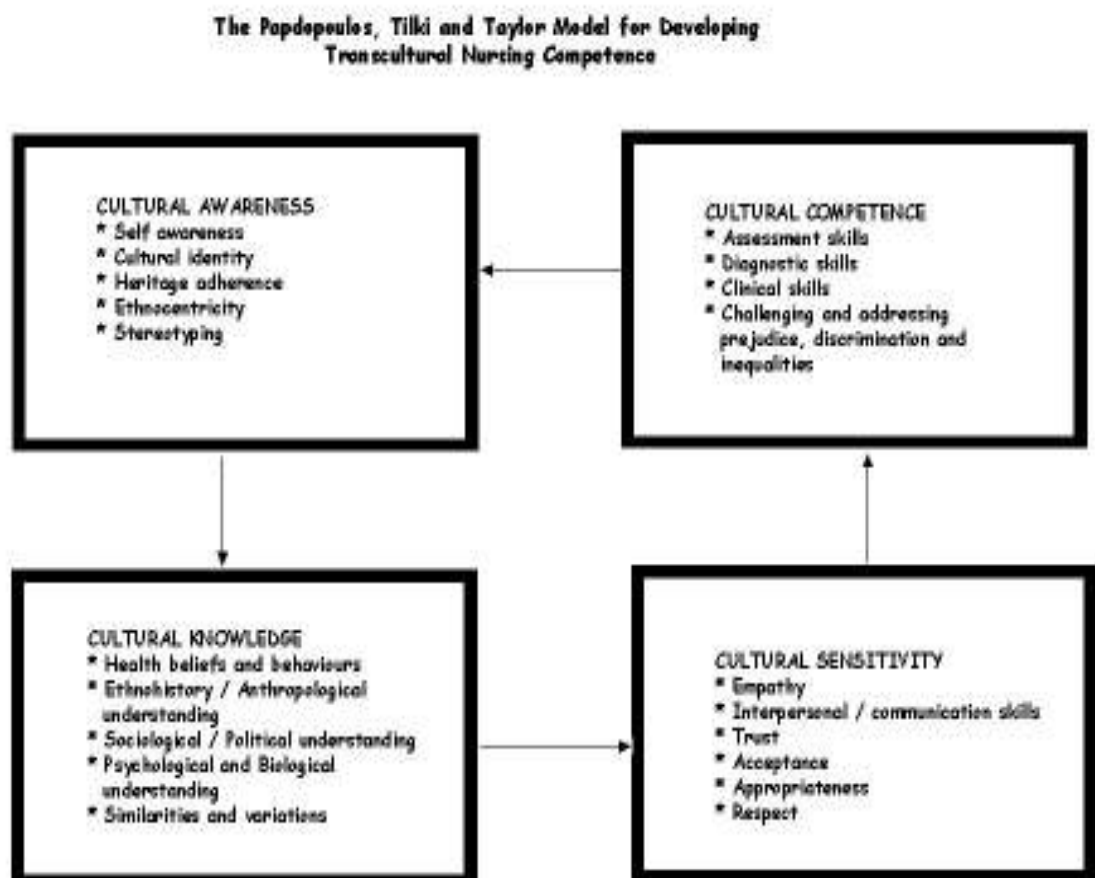
Having considered other models of cultural competence¹², I identified the Papadopoulos Tilki Taylor (PTT) Model for Developing Cultural Competence (Papadopoulos et al 1998) as a suitable theoretical and conceptual model to use for

¹² The literature makes reference to many cultural competence models in nursing and health care. It was beyond the scope of this study to outline and analyse all of them. The majority of models describe cultural competence in terms of the integration of knowledge, skills and attitudes. Most of them reflect the theoretical principles of Leininger's Cultural Care Diversity and Universality theory. What remains central to all of them is the focus on personal and professional development, learning and practice.

this study (Figure 1 PTT Model). As the model originates from community nursing and community development experiences, I decided it would be a suitable and reliable resource to aid my own understandings of cultural competence.

The model differs from other more clinical / medicalised models as it explicitly focuses on promotion of equality and human rights based understandings of healthcare and the value of individual and community participation in decision making. A fundamental principle of the PTT model remains a commitment to promoting anti-oppressive and anti-discriminatory practices. Within the PTT model, this core principle is emphasised by acknowledging clients participation in health care decisions. To enable this to be possible, Papadopoulos states:

“...it is imperative that health care professionals recognise how society constructs and perpetuates power and disadvantage” (2006 p8.)



(Papadopoulos I, Tilki M and Taylor G, 1998)

Figure 1

Of significant importance within the PTT model is the awareness and understanding that structures such as society, family or institutions are structures of power which can be enabling or disabling to an individual. This can be replicated within the culture of caring healthcare and health services and applies to both providers and users of healthcare. As a nurse with a background in development studies, I found this approach more interesting and worthwhile.

The PTT model identifies a number of fundamental values that have influenced its development and are key to its application, including human rights, socio-political systems, intercultural relations, human ethics, and human caring.

The authors consider cultural competence both as a process and an output, derived from the synthesis of knowledge and skills that are continuously acquired during one's personal and professional life. The PTT model was further developed to consider culture-generic and culture-specific competencies¹³ and their application in knowledge acquisition and practice (Figure 2).

¹³ Culture generic competencies apply across all cultural groups and can assist in the acquisition of culture-specific competencies. It will never be possible or desirable for a healthcare provider to know all about all cultural groups but through the application of generic competencies, they should be able to acquire the relevant information needed to treat and care for their patient.

Figure 2: The Papadopoulos & Lees Culture-generic and Culture-specific Model of Cultural Competence

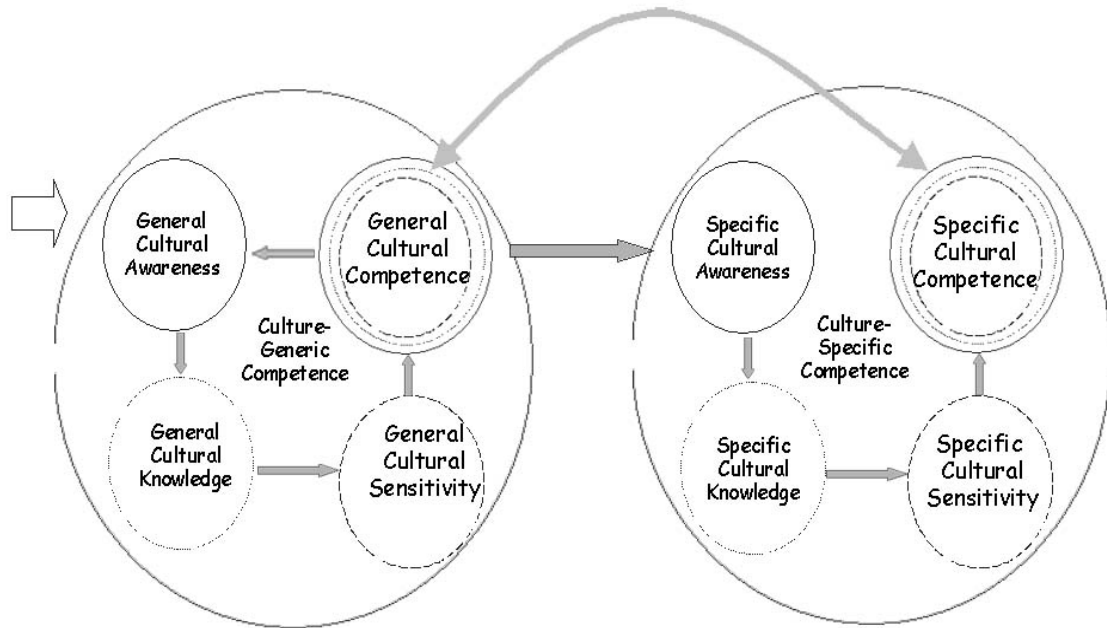


Figure 2

The PTT model (Figure 1) consists of four main constructs that also serve as the four development stages of the cultural competence process and are underpinned by the values mentioned. Within each of these four constructs and development stages, a number of sub-constructs that influence the overall context and development of the stage can exist. These sub-constructs are not fixed and may overlap or be shared between each of the main constructs. The dynamic and fluid nature of these constructs and sub-constructs in itself, demonstrates the ever changing nature of culture and cultural influences.

The four main constructs of the model are as follows:

- Cultural Awareness
- Cultural Knowledge
- Cultural Sensitivity
- Cultural Competence

What follows is a brief description of each of the four constructs and stages of the PTT Model as shown in Figure 1.

Cultural Awareness

Cultural awareness is concerned with the examination and understanding of our own personal values and beliefs and how they are learned and constructed from an early age. We use these values and beliefs to guide our behaviour, decisions, judgements and lives. It is the degree of awareness we have about our own cultural background and our cultural identity. Our values and our interpretations of them are influenced by others such as family, friends and also by our environment and our experiences of living.

Our own cultural awareness contributes to our identity and to the identity of others. An important factor in understanding cultural awareness is our ability to understand the relationship between commonality and diversity in the context of values. Human beings from different cultures may share similar values – e.g., love, family, justice, health and wellbeing- but our interpretations of these values may differ and consequently, may influence how we behave in response to them and to those of others. These interpretations may differ due to other social or cultural factors such as gender, age, social status / class. This can be seen in something as simple as greeting people. In France, it is customary for people to greet with a handshake and a ‘kiss’ on the cheek and this applies across both genders. However, this type of greeting may not be acceptable in some other cultures where values and meanings concerning proximity or gender roles are expressed and maintained based on specific cultural interpretations.

Cultural awareness can be conscious or unconscious (Papadopoulos 2006, Purnell 2006). It helps us to understand the importance of our own cultural heritage and that of others and alerts us to the dangers of ethnocentrism. Cultural awareness is an important first step in helping us to develop cultural competence and in keeping with the model, must be supplemented by cultural knowledge. Sub-constructs that may exist within this domain and that could influence the development of cultural competence include: self-awareness, cultural identity, ethnocentrism, stereotyping, ethno-history, heritage adherence. Within this domain, an awareness of our own biases and how our own cultural background - including class, education, profession,

family status, is important to enable us to reflect on how our own cultural-selves influence our encounters with people from other cultures.

A fundamental component of developing cultural competence is acknowledgment of intra-cultural variation, i.e. there is more variation within cultural groups than across cultural groups. Where individuals are viewed as a stereotype of their culture rather than a unique blend of the accumulation of life experiences and the acculturation to other cultures (Camphina-Bacote 1999, Papadopoulos 2006), further compounding of stereotyping and ethnocentrism will occur. This could further exclude people from health care provision. This understanding is key to a persons' own cultural self awareness and essential to the application of cultural competence.

However, as with other similar models, the PTT model acknowledges that cultural awareness is an antecedent to the acquisition of knowledge and skill. Seright (2007) confirms that the literature is consistent in considering cultural awareness, both as an attribute and an antecedent in the development of cultural competence. He acknowledges that, awareness of one's own beliefs and values is one of the first steps in achieving cultural competency. The PTT model is particularly concerned with the ability of individuals and organisations to analyze our own biases and prejudices and to explore factors, within ourselves and health services (individual care giver / organisation), that may result in discrimination, whether direct or indirect.

Cultural Knowledge

When considering cultural knowledge as one of the four constructs of the PTT model the authors raise a very important question:

“Whatever the source of the knowledge we access to enable us to care for our clients or patients in culturally competent ways, we must always ask ourselves: whose values were used to construct it”?

(Papadopoulos 2006).

The construction of cultural knowledge, in the context of the PTT model, includes an analysis of the concept of knowledge. An understanding of how knowledge, including different types of knowledge (tacit or explicit), is acquired and utilised in the working environment, is a key component of the development of cultural competence (Traynor 2010, Eraut 2000). It is accepted by writers of transcultural health care theory that the

construction of cultural knowledge is complex, multifaceted and multidisciplinary. The diversity in cultural knowledge is as diverse as culture itself (Leininger 1995). The construction and application of cultural knowledge varies depending on context. It is dependent on personal, social, political, organisational and professional interpretations of people's ways of living, people's experiences, behaviours and their associated meanings. However, in healthcare, cultural knowledge can be problematic. It may be viewed as the preserve of specialists or other disciplines and may appear as being unattainable. This is a phenomenon experienced in most working environments in the context of informal learning and professional practice (Hannabuss 2000, Eraut 2004). Indeed, Leininger in her earlier work, has commented that culture is so much an integral part of what we do that we seldom stop to think about it. This lack of reflection has consequences for how nurses and health care staff respond to culture and how they acquire cultural ways of knowing (Schon 1983, Mezirow 1997, Kember 2001).

The construction and acquisition of cultural knowledge takes place within the context of personal, daily-life experiences and also in interdisciplinary professional experiences within the culture of a profession. This may occur within and/or beyond the culture of an organisation. For example, in healthcare this could be in a primary care context or within a hospital environment or within the subculture of a chosen discipline e.g. nursing, medicine, social work. The construction and acquisition of this cultural knowledge may take place within formal or informal contexts and environments. For example, knowledge can be acquired experientially, based on an experience of travelling or living in another culture or social environment, moving job or changing career or, more formally, while undertaking a formal course of study. Moving beyond traditional models of nursing education the PTT model acknowledges the value of interdisciplinary working and education in the acquisition of cultural knowledge from other disciplines such as sociology, anthropology, cultural studies, politics, psychology, medicine, the arts and others (Barrow et al 2010, Traynor 2010). What is common to all of these examples is the meaningful contact that occurs between people of different ethnic and cultural backgrounds (including social class) or of the same ethnicity or nationality. It is this human contact that helps to enhance our generic cultural knowledge and in turn, within the healthcare context, informs specific cultural knowledge related to health beliefs and behaviours. Such cultural

knowledge can assist in applying culturally competent care. Again, and similar to the construct of cultural awareness, in exploring the construct of cultural knowledge the PTT model stresses the importance of understanding the concept of power. Acknowledging power structures, such as professional power and control, can help healthcare staff make connections between personal and professional positions of empowerment or disempowerment and identify structural inequalities that exist within the client/patient and health professional / service relationship (Tilki 2006, Douglas & Pacquiao 2010).

The power of the ‘expert’ (usually considered the healthcare professional), who produces and uses knowledge that can be exclusionary, has to be re-evaluated and carefully considered in the construction and use of knowledge (Benner 1984, Eraut 2004). Explicit in the PTT model is an understanding and acceptance of the construction and acquisition of knowledge, not just professionally but also in the socio-political context. Even though other models (Purnell 2005, Camphina-Bacote 1999) specify the need to achieve understandings of client cultures and differing world views; this can only be achieved by acquiring an understanding of how cultural ways of living, are in themselves, constructed within power relations and social structures. Having this knowledge will enable nurses and other health care workers to apply relevant and appropriate nursing medical and humanistic care – as alluded to by Leininger (1995).

Sub-constructs that may exist within this stage include health beliefs and behaviours, understanding of anthropological, socio-political, and biological influences on health, and an understanding of why health inequalities or disparities may exist.

The PTT model demonstrates that the construction of ‘cultural knowledge’ is complex and involves the, often simultaneous, acquisition and application of other types of knowledge and skills. It is more than simply learning from experience. It is a process that involves, not just learning from other people but about other people, and learning to use scientific or specialised academic knowledge in practice contexts (Eraut 2004). The following construct of cultural sensitivity goes further towards explaining some of these influencing factors.

Cultural Sensitivity

The PTT model describes the construct of cultural sensitivity as being central to the development of appropriate inter-cultural relationships with clients. Acknowledging that cultural sensitivity is achieved through effective transcultural communication, Papadopoulos *et al* (2006) stress that, essential for the construction of cultural sensitivity, is an awareness and understanding on the part of the health care worker of their own position in the client / patient relationship. A key question asked in this regard is “How do professionals view people in their care”?

Again, as is evident with the PTT model, an important emphasis is placed on the concept of power and how this power may be used or misused by the healthcare worker in the context of constructing and developing cultural sensitivity for use in the application of culturally competent care.

Acknowledging that health care professionals in the transcultural context may hold varying degrees of power, constructed in equally varying cultural, social, political, and economic contexts, Papadopoulos *et al* (2003) assert that health care professionals must view their patients as partners in their care. This involves the sharing of power and facilitation of empowerment by providing relevant and understandable information and support in respectful and clear ways. These are key principles in transcultural nursing and in community nursing (Baisch 2009, Níc Philbin 2010).

In summary, when exploring cultural sensitivity, the PTT model advocates equal partnerships in the patient / health professional relationship. Central to this partnership is trust, acceptance and respect on both sides, with an openness to engage in effective and mutually beneficial facilitation and negotiation.

The development and application of cultural sensitivity is complex and challenging for all. It exposes differing beliefs, values and attitudes, derived from personal and professional experiences with others that may have been positive or negative. Similar to the construction of cultural knowledge, the construction of cultural sensitivity must involve a recognition and understanding of status, either social or professional, and the existence of ‘hierarchies’ within communities, groups, professions and

organisations. Such an understanding of these structures and dynamics may help in the negotiation and facilitation of culturally competent care in a culturally sensitive way.

Key to acquiring and practicing cultural sensitivity is the development of effective interpersonal communication, based on trust and respect. If we are to truly acknowledge the value of equal partnerships in the client / health professional relationship, healthcare providers and professionals must establish methods of developing and resourcing effective intercultural communication. In explaining the value of developing effective intercultural communication Papadopoulos (2006) states:

“It invites us stay in touch with our own sense of authenticity, to recognise our anxiety about ambiguity in the situation, to recognise the potential and real challenges to our own values and expectations and to remain committed to making the interaction effective” (2006, p.17)

A willingness to be open and reflective about changing and improving our communication methods and skills in the cross-cultural context is essential. This very practical realisation of the need to be resourceful in our communication style with service users should also enable us as health care professionals to reflect and consider the role of power and empowerment in the transcultural health care context. The application of this type of thinking, may in practice, evoke a conscious acknowledgment of feelings and attitudes related to negative stereotypes that can hinder our work in the cross cultural healthcare context (Tilki and Boyle 2008, Markey et al 2012).

Therefore, this third stage of cultural sensitivity requires an understanding and an acknowledgment by health care professionals that differing beliefs, values, attitudes and experiences can exist for us as health workers that can affect our professional practice with service users. At this stage in the cultural competence development process, knowledge of the complexity of intercultural relationships and intercultural communication is essential, so that all involved can comprehend those factors and variables that may hinder the transcultural health care dynamic.

Of particular significance is an understanding of how core values such as trust and respect are afforded, understood and valued within the healthcare encounter by both parties. As with the previous stages and domains in the PTT model, a failure to consider, explore and understand the sub-constructs relevant to this stage, such as empathy, trust, respect, and appropriate interpersonal communication skills, may result in forms of direct or indirect discrimination such as racism and ethnocentrism when providing health care. In summary, an important element in achieving cultural sensitivity is in tracing how professionals view people in their care. For example, you could look at Leininger's model of Stranger to Trusted Friend (Leininger, 1995). It is essential that a mutually respectful relationship is developed. The next stage of the PTT model (Cultural Competence) includes and acknowledges the construction of inequalities and power imbalances in cross cultural contexts.

Cultural Competence (Practice)

The fourth stage of the PTT Model is Cultural Competence (Practice). Papadopoulos (2006) describes this stage as the synthesis and application of the previous three stages (awareness, knowledge and sensitivity). Due to the practical nature of this fourth stage, it is sometimes referred to as the cultural practice stage. This amalgam of understandings of the previous stages should result in the practice of culturally competent health care by health care professionals.

The skills required for culturally competent practice are multifaceted and, as briefly explained in the previous section, originate from a knowledge base consisting of specific and generic cultural knowledge of individuals and communities, based upon relationship building and intercultural communication. The practical application of these skills in the healthcare context centres primarily upon the acquisition of transcultural knowledge and advocates building upon the existing skills which healthcare professionals possess in needs assessment, nursing / clinical diagnosis and cares (Leininger 1995, Papadopoulos 2006).

Significantly, the PTT model explicitly acknowledges that a most important component of this stage is the ability to recognize and challenge racism and other forms of discrimination and oppressive practices. Therefore, the PTT model and its theoretical underpinnings, stress that the skills based component of the model cannot

be removed from the philosophical values that inform its practice and implementation. Consequently, for nurses and other healthcare professionals to practically apply the PTT model, an understanding of the socio-political concepts of human rights, human ethics and human caring that influence power-relations must be gained and more importantly, reflected upon, in order to achieve culturally competent care. Papadopoulos and others acknowledge that the development of a broader understanding around social inequalities, inter-ethnic relations, social justice and citizenship rights is required by nurses and other healthcare professionals, in order to bring about the change required in healthcare provision and practice. This could allow for a situation where culturally competent care is considered the norm and not an added extra.

This fourth stage of the PTT model emphasises the thought processes and knowledge base of the practitioner, to determine attitude and allow for the skilful application of care. This very important component will have significant practical implications for nurses when providing care to culturally and ethnically diverse individuals and communities. For example, the gathering of information about cultural health beliefs, understanding of health and illness, traditional healthcare systems and practices are all key elements in determining the level of overall competence of the healthcare professional.

In order to achieve the fourth stage of cultural competence, Papadopoulos and Lees (2002) put forward a framework of culture-generic and culture-specific competencies. They explain culture generic competencies as an appreciation of how cultural identity mediates health by exploring and understanding the sub constructs of each domain (stage) and applying them in a generic context. For example, we all have generic cultural lived experiences, knowledge and information from our personal lives. This is informed by the ways in which we have been socialised and how we have learned to behave and respond in different circumstances and environments. These culture generic experiences influence how we respond in the cross –cultural context. In health and social care contexts, once this culture-generic competence is acquired, health care professionals can transfer this generic knowledge and resulting behaviours via the same process to a more specific cultural context and thus begin to process and acquire culture specific competence. The acquisition of culture specific knowledge should

enable the application of culture specific care and result in care that is culturally competent. However, other variables will also influence this application and subsequent outcomes, such as the motivation, interest, learning and reflection skills of the health care worker and their relationship with the client.

Of core importance in the cultural competence (practice) stage is mastering the practical assessment skills, clinical skills, and diagnostic skills. These must be merged with the awareness and understanding of the relevance of the sub constructs for cultural sensitivity, such as empathy, interpersonal communication skills, trust, acceptance, appropriateness and respect. However, cultural competence is not the sole responsibility of the individual practitioner but must also be understood and applied from within the whole organisation. Therefore, nurses and healthcare workers must remain cognisant of the socio-political influences that can impact on health care decisions, e.g., media influences, global issues, economic or political decisions. However, these socio-political influences may also be more subtle and present in the conscious or unconscious attitudes and behaviours of people. It is the amalgamation of the acquired knowledge and understanding from commencing the process at stage one (cultural awareness) and journeying through the next 3 stages, that will empower healthcare professionals to practice culturally competent care. In doing so, they can challenge the issues such as inequality, prejudice and discrimination that continue to negatively affect health service provision and impact on the health experiences of some minority ethnic communities and individuals.

Measuring Cultural Competence: The Cultural Competence Assessment Tool – (CCAT)

Robson (2002) acknowledges that there will be occasions when qualitative researchers draw on quantitative techniques and vice versa. Classifying an approach as one or the other does not mean that once an approach has been selected the researcher may not move from the methods normally suited to a particular context. Similarly, Jones (1994) proposes that interpretative (qualitative) researchers reject the scientific abstraction and quantitative treatment of the human experience. However, she also reminds us that the distinction between abstract, quantitative and ‘scientific’

sociology and humanistic and qualitative sociology is not hard and fast, stating that, at times, researchers may engage and make use of both approaches.

Although primarily using an interpretative methodological approach, I employed a flexible design of mixed research methods. Quantitative methods were used to elicit data about the levels of cultural competence of community nurses, using a cultural competence assessment tool (CCAT) (see Appendix C). Qualitative methods using semi-structured individual interviews were used to further interrogate and explore nurses' transcultural experiences.

The Cultural Competence Assessment Tool (CCAT) was designed based on the Papadopoulos Tilki Taylor (PTT) theoretical model for developing cultural competence (see appendix C). I am grateful to Professor Papadopoulos, who gave me permission to use the CCAT and the corresponding computer software programme for this study. The CCAT was developed in 2002 by Papadopoulos, Tilki and Lees as a self-assessment tool.

The rationale for the CCAT assessment is based on the following principles:

1. Context specificity,
2. Client group specificity
3. Culture-generic and culture-specific competencies.

In the context of this local study these principles correspond as follows;

Context specificity relates to the community health context within a demographically changing population in Liffeside. The client group specificity relates to the community nursing staff working within the six health centres located in the area. The culture generic and culture specific competencies relate to the existing and / or acquired knowledge and skills of the nurses, in the context of their work-based transcultural experiences.

As an exploratory study, the CCAT was employed solely for the gathering and analysis of baseline quantitative data, in response to the research questions in the local context. Due to its limited capacity it was therefore only distributed once for that

purpose. Also, due to the limited scope of the study, it was not intended to undertake participatory cultural competence training and education as part of the research process. Data gathered from the CCAT was intended only as an indicator and as a learning exercise, rather than an objective assessment of cultural competence.

The CCAT is divided into four formal sections (domains) in accordance with the four constructs and developmental stages of the PTT model; cultural awareness, cultural knowledge, cultural sensitivity, and cultural practice. The CCAT also contains a separate respondent profile section. This section provides an opportunity to gather and consider a number of personal and professional variables that can be anonymised. Primary cultural characteristics such as gender, age, religion, nationality, ethnicity in addition to data on education, and qualifications can be collected. The interplay and amalgamation of personal and professional knowledge and experiences overtime inform the behaviour, attitudes and interactions of health care professionals (Purnell and Paulanka 2003, Brach et al 2000). However it must be noted that there is a complexity in the inter-relationship between variables and that alone these variables are not specific indicators of levels of cultural competence. Although limited in value, the gathering of this data can assist with informing our understanding of cultural competence development.

Each of the four sections of the CCAT contains a list of ten statements laid out in a Likert scale format. Each one of the statements is marked individually by choosing one of the options, *strongly agree*, *agree*, *disagree* or *strongly disagree*. Each statement is allocated a score. All statements must be ticked, as leaving blank boxes or responding 'not applicable' will negatively affect the overall score.

A specific score sheet and plan outlines the allocation of points for all four domains in the CCAT. For example, each correctly answered statement is allocated one (1) point and incorrectly answered statements receive zero (0) points. The maximum total number of points that can be achieved in each section is ten (10) points (1 point per each correct statement). When all four sections of the CCAT are completed the total maximum number of points that can be awarded is forty (40) points. A person is considered to be culturally competent if they achieve a total score of forty (40) points, comprising a score of ten (10) in all of the four sections.

All ten statements in the first section or domain of *cultural awareness* are culture generic. As cultural awareness is the prerequisite for determining cultural competence – a score of less than five in this section (regardless of scores achieved in the following three sections) automatically confers a level of cultural incompetence.

In each of the other three sections (cultural knowledge, cultural sensitivity and cultural practice), the ten statements are presented as follows: four statements are culture generic and six statements are culture specific. These are not identifiable to the respondent. The responses are allocated a score and this is used in the calculation of the level of cultural competence. The overall level of cultural competence is determined by the scores achieved from completing all of the ten statements in each of the four sections of the questionnaire. The score sheet is derived using the software tool designed to analyse the responses.

The scores and information from the completed questionnaires (CCATs) are entered into a specifically designed and copyrighted CCAT software programme for analysis. The CCAT determines four levels of cultural competence development. The level of cultural competence is calculated by the software formula which then assigns the level according to the following criteria:

- **Cultural Incompetence (CI).** A person is culturally incompetent if they receive a score of less than 5 in the cultural awareness domain. This applies regardless of their score achieved in the other three sections of the CCAT.
- **Cultural Awareness (CA).** A person is culturally aware if they have achieved a score of 5 or more in cultural awareness without necessarily having all of the generic statements in the other areas correct.
- **Cultural Safety (CS).** A person is considered culturally safe if they have achieved a score of 5 or more in cultural awareness and have all the generic statements correct in the other sections.
- **Cultural Competence (CC).** A person is culturally competent if they have achieved a score of 10 in all of the four stages (total of 40 points).

In addition, each of the four sections of the CCAT contains a subjective measurement tool, Visual Analogue Score (VAS) where participants can score themselves. These VAS Scores are assigned by participants along a linear gradient of points scored from 1 to 10. The self allocated VAS scores in each section correspond with a continuum of awareness, knowledge, sensitivity and competence. The lower points indicate lower levels of the stages in cultural competence development by respondents, whereas the higher scores indicate higher levels of cultural competence development as self scored by respondents. The VAS self assigned scores attempt to capture two dimension; the conscious – unconscious and incompetent to competent levels of cultural competence. The benefit of the VAS score is that participants can compare their perception of their scores in each area with the actual scores achieved in their responses to the culture generic and culture specific statements.

For example, within cultural knowledge, participants can compare their scores achieved from the statement section in cultural knowledge to their self assigned VAS score on cultural knowledge. This allows for some degree of analysis, allowing the researcher to compare personal perceptions of cultural competence with objective scoring, while also allowing participants to reflect upon their own experiences and learning styles (Papadopoulos et al 2004).

However, this in itself is not a complete indicator of cultural competence, as many other complex factors can influence the scores and outcome. For example, in some instances, a lack of knowledge, skill or awareness combined with embarrassment or a false sense of knowledge can lead to a respondent giving a high self assessment score. In turn, while the acquisition of newly acquired knowledge is of benefit, uncertainty or apprehension about being exact and accurate may lead to low self assessment by others. In addition, it would appear unlikely that the majority of respondents could achieve the perfect score of 40 points deemed necessary to allocate them the level of ‘culturally competent’. Consequently, only limited interpretation drawn from the CCAT is possible.

As a quantitative data collection method the CCAT is not without limited use. Robson (2002) identifies the limitations of survey questionnaires, remarking that they generally tend to provide descriptive information only. Practical barriers associated

with dissemination and collection can result in extended delays in data being returned. In addition, there is an increased risk of error where participants misunderstand instructions that can result in inaccurate or incomplete data. Problems also include motivational factors for respondents in taking the time voluntarily to complete questionnaires. This can be further compounded within the busy working environment.

Consequently, in considering these methodological and practical concerns, I employed a mixed-method, flexible approach to enable further interrogation of the data via qualitative methods.

Qualitative methods: Semi –Structured Interviews

In applying a mixed methodology in this study, I was aware that interviews may provide an opportunity for further exploration and follow-up of interesting responses from participants that self-completed surveys or questionnaires cannot. Some have described interviews as conversations with a purpose (Lincon and Guba 1985). The researcher and the participant are involved in an interactive relationship which is much closer than in quantitative research.

Individual semi-structured interviews were employed as a qualitative method for this study, as they yielded further and richer data in answer to my research questions. Within social and human sciences the interview may serve very different purposes. It can serve as a means of studying ways of doing and seeing things, peculiar to certain cultural groups or cultures (ethnography), or alternately, studying the way individuals see themselves and others in certain situations (psychological perception). It can also be used to study the way people feel about certain issues (social opinion) (Van Manen 2007).

Semi-structured interviews enable participants to address issues of importance to them and are an effective way of collecting such information. This can be noted particularly when researching sensitive topics, as not all research participants may be comfortable within a group interview or focus group. Therefore, the individual semi-structured interview affords some safety and structure for their participation. Face-to-face

interviews also provide opportunities for observing non-verbal cues and nuances in interviewees that may enable opportunities for acquiring further data and subsequent interpretation. However, caution is required in unstructured or open interviews as there is a risk that the researcher may become disorientated from the line of enquiry and research questions (Silverman 2010, Van Manen 2007).

Robson (2002) acknowledges that the semi-structured interview is widely used in flexible research designs, suggesting the use of a qualitative interview is appropriate where a quantitative study has been carried out and qualitative data is required to validate particular measures or to clarify and illustrate the meanings of findings.

In addition, interviews afford some flexibility for the researcher and offer an opportunity to modify the line of enquiry allow participants to recall and generate accounts and explanations of their experiences that may not be anticipated (Silverman 2010, Van Manen 2007). Such disclosures may be explored in the context of allowing participants an opportunity to derive their own meaning and also enabling understanding to emerge from recollection and reflection on anecdotes, stories, experiences or incidents. Interviews allow for closer examination of complex issues and afford an opportunity for exploration of the inconsistencies and contradictions that very often reflect the reality of people's lives. According to Fain, (2004) lived experiences consist of everyday experiences of an individual in the context of normal pursuits and focus on "what is real and true" to that individual (Fain 2004).

Within the interpretative research approach the researcher must remain cognisant of the fact that interviews do not aim to explain, predict or generate theory but are instead concerned with understanding the essence of a person's experiences, complete with the detail and content that shapes that experience. Indeed Silverman (2010) cautions us on the methodological debate on whether interview responses should be viewed as giving direct access to experiences or viewed as actively constructed narratives, involving activities which themselves demand analysis (2010 p.48).

In keeping with the overall aims and objectives of this study and the research questions, the qualitative methods (semi-structured interview) aimed to expand on the following:

- The nurse's experiences and understandings of cultural competence and transcultural nursing in their practice.
- The nurse's responses such as attitudes and behaviours to cultural issues in their practice.
- Elicit nurse's perceptions of their knowledge and/or skill development when working in a culturally diverse setting
- To identify and elicit the extent of education and training received by nurses, either formally or informally, in the area of cultural competence or transcultural nursing.
- To clarify and elicit further data and issues emerging from the CCAT and to enable some comparison for more detailed analysis of the findings.

As it recommended that interviews be recorded and field notes taken, the time-scale associated with accurate transcribing can be significantly high. I found this to be the case for this study but was aware of the advantage it provided in allowing me to remain close to the data.

On reflection, in the process of conducting the interviews as a novice researcher, I have learned that interviews require significant skill (practice) and involve careful planning and preparation. For example, the designing of an appropriate interview schedule or topic guide and the practical logistics of travel, time and costs (resources and financial) needed a great degree of planning. Interviews may be unpredictable in terms of the actual environment and the level of engagement of interviewees. This may affect the quality and amount of data gathered. As with any research methods, there are also ethical considerations that must be considered. A number of these will now be outlined in the following section.

Ethical Considerations

All research has ethical implications. Regardless of whatever domain ethics is being applied to, (health, education, politics, research, professional life, private or public relations) a fundamental understanding is agreed that sees ethics as concerned with power, power relationships and power sharing. Ethical issues are mainly concerned

with a balance between protecting the rights of people; for privacy, safety, confidentiality and protection from deceit, while at the same time allowing the pursuit of scientific endeavour (Council of Europe 1996).

Prior to commencing the study, the appropriate category of ethical approval was approved by Middlesex University Health Studies Research Ethics Sub-committee. As a professional nurse I was familiar with the Code of Professional Ethics and Conduct for Nurses (An Bórd Altranais 2000), including the ethical model of Beauchamp and Childress (2001). They propose a framework of four principles of ethics that are said to express the basic values binding on all persons in all places. These principles are outlined as respect for autonomy, beneficence, non-maleficence, and justice. However, Gallagher (2006) acknowledges that due to the diversity of ethical accounts and approaches that exist in multicultural societies, a number of theoretical and practical challenges arise for the health care practitioner and researcher. These arise as professional healthcare ethics predominantly have their origins in Western philosophical traditions. Non-Western approaches to ethics generally stem from equally complex philosophical and religious systems that sometimes conflict and are sometimes amenable (Gallagher 2006, Leininger 1995). Therefore, the question asked of such approaches is, are they truly universal and appropriate for consideration in the development and application of cultural competence in health care?

In the general context of undertaking research, Silverman (2010) articulates the practical application of these ethical principles (autonomy, beneficence, non-maleficence and justice) and outlines them as follows:

- Voluntary participation and the right to withdraw
- Protection of research participants
- Assessment of potential benefits and risks to participants
- Obtaining informed consent
- Not doing harm.

Robson (2002) suggests that in theory and practice the ethics of researching goes beyond consent, confidentiality and respect for the participants, due to the

collaborative and genuine participation between the researcher and the researched. This poses a particular challenge to the researcher seeking to maintain a fair balance of power within the decision-making area of the research process. Ethical considerations in the research of socially and politically sensitive phenomena have also been highlighted in the literature (Beauchamp and Childress 2001, Gallagher 2006, Papadopoulos 2006).

In the current climate of economic recession, healthcare cuts and social and demographic change, the ethical and political implications in undertaking a study on transcultural health cannot be ignored. In researching the experiences of nurses in response to cultural diversity and ethnic minority group needs, I expected that some objections and questions may be raised by various stakeholders. Consequently, I also anticipated that some participants may not respond to the survey and / or the interviews, as the nature of the research would involve probing and exploring sensitive, personal and professional development issues, including those relating to my own involvement in the research.

In the context of cross-cultural research and health care, the 'positionality' occupied by the researcher or healthcare professionals and the ways in which representational discourses can reproduce or exacerbate the subordinate position of immigrants and feelings of 'otherness' should always be considered (Bhopal 2007). Hall (1997), exploring representation of other cultures, suggests that researchers should recognise that representation involves social conventions and unequal power relationships and should be aware that multiple discourses on social issues often involve conflicting perspectives. These perspectives influence our interpretations and our presentation of data. We are reminded about the connection between power, language and knowledge and realise that they are all influenced by the historical specificity of a particular discourse of representation, at a particular time, in a particular place.

I endeavoured to achieve an understanding and meaning of ethics that is public, communal and constitutes a social enterprise, concerned with objective power-sharing relations. As the study focused on a specific discipline (nursing) and service (health care) within a corporate structure (Health Service Executive), it was important for me that the ethics underpinning the study related to what I perceive to be the public

accountability that exists within public corporate structures (Thompson 1994). In addition, my professional and ethical obligations as a nurse, as defined by the Code of Practice, were a key component in helping me to understand my ethical position in this research process.

The need for research participants to have a choice about participation in a research study is a fundamental obligation in relation to respect for autonomy. In summary, this means that an individuals' decision to participate in a study must be voluntary, without coercion and informed. One of the key principles for conducting ethical research is that participation is voluntary. When conducting this study, I emphasised to participants the voluntary nature of participation and their right to withdraw at any stage.

The concept of informed consent assumes that in order for individuals to make informed choices on whether to voluntarily participate in the research; they will require information about the study (Robson 2002). In carrying out this study I distributed the Participant Information Sheet (PIS) (see appendix B) to all prospective participants, which contained detailed information on the purpose of the study. However, as the researcher, I acknowledged that informed consent was not limited to a one-time information giving session and that the language of the consent and information about the study must be easily understood by the prospective participants, allowing them adequate time to decide to participate in the study (LoBiondo-Wood and Haber 1998). Therefore, opportunities to seek further clarification were also offered by me to the participants who received my contact details (phone and email). For the qualitative phase of the research, consent for interviews was obtained in writing from the participants. The consent also outlined the purpose of the study and informed participants they could withdraw from the study at any stage. My ethical obligation to do good and to minimize harm, required that research participants were informed of my obligation and intentions to protect and support them during the research process. This meant that the study and its findings would be useful and truthful and serve society in a positive way, while also contributing to a body of professional knowledge.

Based on the right to privacy, the participants had the right to anonymity and confidentiality and the right to assume that their contribution to the data would be

kept confidential. In respect of confidentiality, all surveys, interview tapes and transcripts (hard and soft copies) were kept in safe keeping by me. I gave assurances that the storage of all data would comply with data protection obligations (Office of Data Protection Commissioner 2007) and with HSE policy on data protection in the workplace.

Participants were assured the data was collected and used for the purposes of this study only and that all written information was secured in a password protected file on a secure lap-top and was codified by me so as to uphold anonymity of participants. Tape recordings from interviewees were kept in a locked cabinet and only used by me during transcribing and would be destroyed once transcribed.

In addition, to facilitate anonymity and protect the identity of interviewees, data was reported in such a way that personal identity could not be ascribed to any particular individual. Participants were also made aware of their right to request a copy of their own transcripts at any time during the research process for matters of clarification. They were also made aware of their right to access the report findings once fully completed and were informed that they would be notified of its publication.

In considering the fourth principle of Beauchamp and Childress' (2001) framework of research ethics, i.e. Justice, the researcher is obliged to treat each participant in a fair and just manner. For the study I attempted to adhere to this principle by making myself available to participants for clarification on the purpose of the study and/or clarifying their participation in the study. In facilitating the voluntary nature of their participation I respected their chosen preferences regarding location, times, venues, punctuality and requests for further information whenever possible, thus minimising any level of inconvenience that may have been inadvertently caused during the research process.

In addition, when participants enquired about and requested specific information on transcultural health care and nursing issues that arose during interviews (e.g., clinical related matters, perhaps advice on accessing or obtaining information guidelines on infant male cultural circumcision, using interpreters, migrant health policies related to DOTS (direct observational therapy) etc.), I was keen to share and convey my knowledge and resources with them. Of course this was reciprocated by some

interviewees who chose to share some of their own learning and resources. These occasions usually occurred after the 'official' interview when the recorder was switched off and participants were more relaxed and engaged in a free flowing conversation.

During some of the interviews, I, at times, observed a palpable degree of discomfort and sensitivity from participants who were conscious of presenting and explaining their experiences in a professional ethical manner. However, on reflection I found myself asking 'whose ethics were applicable – the nurses or the service users?' This mostly arose in the context of my own initial interpretations of the experiences and responses of participants to cultural practices mentioned and also to their responses to racism as a form of discrimination in the work place. Consequently, at times I felt my own personal and professional ethical position was being challenged.

I was confronted with exploring my own ethnocentrism and understandings of ethics in response to participants' descriptions. Within the research process there were occasions where I felt like the 'other' and not the 'insider'. Such experiences required me to become more aware of preconceived notions I had about the research topic and participants and required reflection on the likely consequences of these.

On reflection, if I'm being honest, I found myself judgemental at times in response to some participants' experiences and descriptions and this challenged me.

In an effort to overcome this bias I attempted to suspend my own personal thinking and to conduct the research process in a professional manner. I needed to remind myself of the opportunities I had gained for establishing support and the acquisition of specialist knowledge and how I too had worked through a process of professional and cultural competence development that was similar, yet different, to the experiences I was witnessing.

However, none of the situations I encountered during the study were of sufficiently serious nature to require reporting to line management or sanctioning within a code of professional ethical conduct. They were carefully considered by me and generally related to my own discerning of ethical issues during the research process. I also sought advice and direction at times from my academic advisor and project consultant.

Robson (2002) acknowledges the existence of such dilemmas and advocates a response similar to that followed by me in this case. However, he also suggests an alternative scenario that posits, after further thought and discussion, the researcher comes to the view that what initially disturbed him / her may be commonplace in the research setting and perhaps they are seeking to impose their own values and expectations; whereas the ethical course is to try to seek an understanding of what is going on by 'telling it as it is'. He further reminds us that

"...while you have particular ethical responsibilities as a researcher, this does not mean that you have a privileged voice on what constitutes ethical behaviour in others." (2002, p. 71)

Due to the work based context and my familiarity with some of the research participants I remained cognisant of the possibility of positive research bias in the responses of some interviewees. However, this could not be automatically assumed in the majority of cases and I am confident of the credibility and trustworthiness of the content and information gathered.

I was very grateful for participants' contributions to the study and this was acknowledged by way of a simple 'thank you card' distributed to the nursing staff in the health centres that participated in the study. They were also made aware of the intentions of use of the information emerging from the study. They were encouraged to access any reports or attend any presentations of data. This was to allow for questioning and / or to enable and empower any nurses interested in using the data to inform their own further research in the area.

Chapter Four: Project Activity

Quantitative methods: Using CCAT

Following ethical approval (see appendix A), I sought permission by personal communication with Professor Rena Papadopoulos, the lead author of the PTT model and designer of the copy righted CCAT, to use the tool for this research project including use of the specific data analysis CCAT software. Permission was kindly given by Prof. Papadopoulos to whom I am grateful. The suitability of the instrument to the local context was considered collaboratively with my academic advisor, a co-author and designer of the PTT model.

Pilot with CCAT

For the purposes of identifying unconsidered barriers and practical difficulties using the CCAT survey, I undertook a pilot of CCATs within a small cohort of community nurses (n=5) and a subsequent focus group interview. This enabled me to check issues such as the reliability and convenience of the internal post system and to familiarise myself with the CCAT pre-and post completion. Some slight amendments were recommended to suit the local community nursing context and these were made with permission. The modifications only concerned the respondent profile section. Changes were not made to the overall CCAT generic and specific statements or the visual analogue score (VAS) statements in the four principal domains of the CCAT, as the pilot and the focus interview indicated that the original statements from a previous Delphi study on design of the CCAT for public health nursing were relevant to the local community nursing context intended for this study. Following referral to, and discussion with, my project and academic advisor, I proceeded with the study as planned.

Research Site

After receiving ethical approval from the university to proceed with the study, I made an application for access to the research site i.e. HSE primary health centres in Liffeside health service area. Access was approved by the local HSE Primary Care

Management Team, Local Director of Public Health Nursing and Local HSE Manager for Services for Social Inclusion. The HSE National Assistant Director of Services for Social Inclusion gave organisational approval for the study to take place within the HSE.

The research site for this study comprised of six Health Service Executive (HSE) community health centres located in the Liffeside health service area. Each of the centres differed in size. The number of nurses allocated to each centre is determined by population health statistics specific to the electoral divisions within the Liffeside health service area. All health centres accommodate HSE community nursing services on-site, providing various nursing clinics to the public; wound dressing, vaccinations, child development etc. In the main, community nurses base themselves in their allocated health centres for scheduled clinics and administrative work. However, a significant amount of community nursing work is undertaken within peoples' homes.

Research Population

The research population for this study was the population of community nurses working in the six HSE health centres in Liffeside. The total research population comprised of those nurses working under the direct line management of the HSE Director of Public Health Nursing for the area. The total number of community nurses working in all six centres in Liffeside health service area, that satisfied the inclusion criteria, was 39 nurses and 5 nurses with additional service administration responsibilities in the Liffeside health service area. The research criteria excluded GP practice nurses and community psychiatric nurses, as the former work in a private capacity in GP practices, and psychiatric nurses work within a different nursing management structure and health service employment context i.e. community mental health nursing. Therefore, the total research population (100%) consisted of 44 nurses (n=44). This included a mix of nursing staff working full-time and part-time hours. It consisted of public health nurses (RPHNs), community registered general nurses (CRGNs) and community registered midwives (RMs), all working in the public health nursing service of Liffeside.

Distribution of Participant Information Sheet (PIS) and CCATs

The Participant Information Sheet (PIS) (see appendix B) was compiled in accordance with the standards outlined by the university ethics committee. It outlined the background and purpose of the research and ethical approval guidelines, including the voluntary, anonymous and confidential nature of participation, research methods, my professional profile, level of research supervision and my contact details. The purpose of this was to enable nurses to make informed decisions and make any enquiries, comments or suggestions as they so wished. The CCAT contained a letter and cover-page, including instructions for completing the survey questionnaire, along with a return-addressed envelope and the specified return date.

Following meetings with the Director of Public Health Nursing, I was given permission to access a staff database for the purposes of this research only. The data base contained limited professional information of nurse's roles, areas of responsibility, nursing qualifications, and their health centre locations. Such information was important in the selection of purposive sampling at a further stage in the study. It was not used for any other purpose, nor was its contents disclosed to others and usage was in keeping with confidentiality and data protection guidelines. Once I had used the database for this purpose, it was destroyed.

The PIS and CCAT were distributed via the internal staff postal system to all nurses in the area 44 nursing staff (n=44). The postal system is reliable and used daily for all internal HSE local area correspondence between multidisciplinary staff and services. Therefore, nurses were very familiar with its use and access to it was unproblematic. Also there were no cost implications for individual participants with postage. Participants were allocated a 2 week period for completion and return of the CCATs via the same internal post. As participation was voluntary, the return of completed CCATs indicated consent.

Completed CCATs Returned

As anticipated and in keeping with survey questionnaires (Robson 2002, Silverman 2010), the surveys were slow to come back and by the return deadline only a total of 9

or 20.4% (n=9) completed surveys had been returned. I felt this was an insufficient sample from which to derive enough data. On further enquiry it was revealed that a number of nursing staff were on sick leave, annual leave and some had commenced maternity leave between the initial period of distribution and the time for completion and return. I did wonder whether utilising an internal postal system for research purposes might lead some participants to question its integrity and reliability, particularly in the context of maintaining anonymity and confidentiality within a work based environment. However, on balance I believed that the measures I had taken to protect the participants were adequate. In addition, due to HSE staffing embargos and a moratorium on recruitment of staff it was not possible to increase or distribute additional surveys.

Consequently, I notified all six health centres again, informing the nursing service of an extended return deadline of ten days. During this period, in the course of my work, I visited each health centre once and met with the nursing staff collectively in each of the six centres. As the survey was anonymous I was not aware of who had or had not returned completed surveys and I requested all participants to return the completed surveys in the internal post by the new deadline. I was conscious of any unfair advantage that an over extended timeline would have on influencing the findings. Examples could include respondents accessing specific information related to the measurement tool and / or the research topic or the possibility for staff to confer with each other when completing the surveys. However, for various reasons there was no alternative. The research period coincided with a programme of rationalization within the local HSE area. Increased work commitments and additional duties due to re-deployment contributed towards significant time constraints that militated against any further extensions to the extended deadline for this quantitative part of the study.

A total of 24 completed CCATs (n=24) were returned out of the 44 (n=44) distributed by the extended deadline date. This constituted a 54.5% response rate and an overall improvement on the rate (20.4%) from the original return date. In consultation with my academic advisor, I considered this a valid response rate for the quantitative purposes of the study and therefore proceeded to analyse the data as per the CCAT software for scoring and appointing cultural competence levels. On receipt of completed CCATs ethical considerations dictated that I provide the safe and secure

storage of hardcopy paper files (CCATs and notations, journal) and related electronic data i.e. CCAT Software and score sheets. Hardcopy data were stored in a locked cupboard when not in use, within a locked office, accessible only to me. Computer files were stored in a user and password protected secure computer file to which only I had access. Presentation and analysis of the findings for this quantitative part of the study will be outlined later. The following section outlines activities for the qualitative methods undertaken.

Qualitative Methods:

Sampling

In addition to the application of limited quantitative methods, my chosen approach afforded further qualitative exploration using semi-structured interviews. Qualitative investigators are of the opinion that knowledge about humans is not possible without describing the human experience and behaviour in the context in which it occurs (Polit and Hungler, 1999, Van Manen 2007).

When undertaking qualitative research, Smith and Osborn (2007) acknowledge the usefulness of the purposive sample in the interpretative approach. As I intended the study to be exploratory and in-depth, I aimed to maximise this by using a purposive sampling method for the interviews. I felt this would capture the complexity and nuance from the participants' accounts and experiences. The purposeful sample was selected from the total sample of community nurses used in the quantitative study. The total population for the study consisted of forty four nurses and fifteen were purposively selected for the qualitative part of the study.

Silverman (2010) reminds us that purposive sampling demands a critical thinking approach about the parameters of the population we are studying and advises we choose our sample case carefully on this basis. I discussed this aspect of the qualitative process with my academic advisor and the Director of Public Health Nursing (DPHN). Permission was given to me by the DPHN to use an administrative staff database in assisting with the selection of the sample and the drafting of specific relevant inclusion criteria. The database information used to convene the sample was used solely for the purposes of this research project. I adhered to HSE data protection

guidelines and HSE research ethics policy in accordance with the participant information disseminated at the outset.

I wanted to capture a broad and rich variety of experiences from the community nurses in Liffeside. Therefore, selection criteria relevant to the aims of the study and the research questions were considered. These included the health centre location; home visiting and / or clinic based work; professional nursing qualifications and skill mix; particular roles of responsibility and the number of years working in Liffeside. The sample comprised of Community Registered General Nurses (CRGNs) working primarily with adults, Community Midwives, Public Health Nurses (PHNs) with a specific child health remit, nurses working with Travellers, nurses working with older adults and those in a shared role with nursing administrative / managerial responsibility.

I selected nurses from each of the health centres in the HSE Liffeside area in an effort to broaden the accounts of nurses' transcultural experiences. Health centre location was significant, as some centres in Liffeside were located in areas with a higher density of cultural diversity and ethnic demographic profile. My own knowledge of the area and data from HSE mapping, including the Central Statistics Office, indicated this point, for example, some areas of Liffeside were more Black African or Asian, while other parts were more Eastern European or 'White'. Consequently, I anticipated variations in nurses' experiences and I was keen capture a variety of accounts from nurses working with many different cultural groups.

I was also aware of nurses who had recently commenced work in the Liffeside area and who had come from less culturally diverse HSE areas in Dublin city. I was interested in including their experiences in the study and anticipated that their inclusion would provide some experiences of transition and adaptation from a more monocultural to an intercultural work-based dynamic.

I considered the length of time that staff had been working in the Liffeside area was significant. I felt such accounts would demonstrate the impact of rapid and unprecedented change in the context of local population demographics and the development of their cultural competence. I was hopeful their accounts would provide

an opportunity for comparing and contrasting experiences over time and provide an insight into how this may have influenced their practice, attitudes and behaviours.

Although all nurses were community based, I wanted to include a variety of skills and the different professional roles, including their main location of work. For example, nurses who were mostly providing services to families within the home environment (home visits) and those who were more clinic or health centre based. In general, home care nursing tends to involve more practical 'hands-on' nursing care procedures and interpersonal relationship building. Whereas health centre or clinic based nursing tends to be more clinical in nature and delivers services as health promotion and education, child health and development clinics. I considered these broad types of experiences would produce mixed and varied accounts of nurses' work-based reality. For example, in the home situation, when dealing with families and individuals on aspects of care, nurses maybe more exposed to the cultural beliefs and understandings of health and illness held by people. Consequently, it was worthwhile considering if nurses' accounts differed or were similar while working alone in people's homes or within the multidisciplinary team based infrastructure of the health centre (clinic) and to consider how this may have influenced their cultural competence development. Another example of this may reveal how they felt supported and resourced in both work environments and how this influenced the types of transcultural experiences that occurred for them.

I felt the inclusion of specific roles by community nurses was significant in establishing the sample. A mix of nursing disciplines widens the variation of experiences that arise and may yet reveal similar and contrasting accounts from which to derive different meanings and understandings. For example, I anticipated that child-health nurses may encounter a broad range of transcultural issues, such as child rearing and parenting practices that could influence practice and attitudes and the development of their cultural competence, areas like feeding or weaning practices, types of food, interpretations of child safety and welfare.

By contrast, nurses working with the older population would perhaps encounter different experiences from their work with culturally diverse families who had elderly relatives living with them. Involvement in the care of elderly in such cases may reveal

specific cultural issues and whole family dynamics within a transcultural context not usually experienced by nurses. I was aware that HSE community services have a significantly low population of elderly adults from ethnic minority and immigrant families receiving care and therefore this provided an opportunity to explore experiences from those nurses.

Historically, as the Liffeside area has a significant population of Travellers, I felt the inclusion of nurses working specifically with Travellers would allow for some level of exploration on the development of cultural competence. For example, it would afford an opportunity to explore whether these nurses had a more informed understanding of concepts such as ethnicity and culture and whether they worked from a human rights and social inclusion perspective as opposed to a medical model of public health nursing. This would allow for some comparison and contrast with the experiences of general community nurses in the context of working with minority groups and wider cultural diversity in the area.

I anticipated that this mix of nurses for the purposive sample would produce a fuller and more in-depth account of transcultural experiences in the Liffeside area. I felt this varied and purposeful sample would uncover knowledge, understanding and experiences not previously explored or researched in community nursing in the HSE. I intended that this qualitative aspect of the study would disclose important local idiosyncrasies including possible inconsistencies, complexities and contradictions that may exist in the everyday real world experiences of community nurses and the service in Liffeside. The following section will outline the methods of data collection for this phase of the study.

Data Collection:

All 15 nurses that comprised the purposive sample were sent a cover letter outlining the voluntary and confidential nature of the interviews and an interview consent form (see appendix B). I also included a blank timetable (schedule) for each person to assign a suitable date, time and venue for interview. Participants were also given my work mobile phone number and email contact details in case they needed to contact me for clarification on any matters concerning their involvement. Interview

participants were asked to return their signed consent forms including their chosen interview date via internal post by a specified date. Returned forms, signed and completed indicated consent to participate.

Prior to the undertaking of the interviews, I wrote a cover letter to each potential interviewee referring them to the Participant Information Sheet (PIS) containing the terms and conditions of the interviews. The following criteria applied;

- Interviews were voluntary and required signed consent.
- Withdrawal from the process at anytime by a participant without explanation was possible.
- Interviews were conducted in the participants' work place or in a convenient and suitable location for the interviewees.
- Interviews lasted no more than forty-five minutes.
- Interviews were recorded for the purposes of transcription by the researcher.
- Interviewees were informed that recordings of the interviews (tapes & transcripts) were stored securely on password protected lap-top and in locked facilities when not in-use and would be deleted after use by the researcher.
- Interviewees were informed that data and excerpts from interviews will be presented in such a way as to keep participants anonymous.

Of the fifteen nurses chosen for the purposive sample, a total of ten nurses returned signed consent forms by the given date. Due to leave and increasing work commitments, I was not in a position to extend the deadline. Following discussion with my academic advisor, the response rate and uptake for the interviews was deemed appropriate for this qualitative phase of the study and I proceeded. Prior to the interview dates I contacted each interviewee to ensure their availability and confirm the time and venue. This was done due to the sometimes unpredictable nature of the participants' work. Dates and times were confirmed and changed if necessary. Respondents were also reminded of their right to withdraw from the study at any time.

Pilot Interview

Before undertaking the real interviews, I conducted a pilot interview with two work colleagues who possessed much of the same characteristics as participants from the purposive sample (i.e. a community nurse / midwife working with a culturally diverse population). The pilot interviews were also undertaken in a similar environment (i.e. place of work / community health centre). The aim of this pilot was to help establish and identify any practical difficulties that potentially could be experienced during the interviews. It allowed me to become more familiar with using the recording equipment effectively and to reflect on the use of the interview topic guide. In addition, it provided an opportunity to consider my interview technique and to hone interpersonal communication skills such as demeanour, positioning, facial expressions, tone of voice and how to use appropriate probes and prompts, including silence. The pilot interviews also enabled me to become more confident and to consider skills to address my own apprehension and vulnerabilities. It also allowed me to consider effective use of the interview topic guide. Practical issues such as the consideration of time management resulted in me reducing the duration of the interviews to forty-five minutes. The pilot interviews also allowed me to consider my methodological approach and aspects of my own subjective bias in conducting the research. I also became more acutely aware of being an 'insider' researcher and of the effect this may have on the research process. It allowed me to consider my own role to date within the community nursing sector and how this may affect the dynamic of the interviews and the emerging responses from participants. Consequently, slight practical re-adjustments were made in advance of the participant interviews and I remained committed to the interpretative qualitative approach I had chosen in attempting to analyse and extrapolate meaning from the data.

Semi-structured Interviews

Van Manen (2007) and Smith and Osborn (2007) suggest interpretative, phenomenological approaches require flexible data collection methods and propose semi-structured interviews as a reliable method. This form of interview allows the researcher and participant to engage in a dialogue that enables the modification of

initial questions in the light of the participants' responses. It also allows the investigator to probe interesting and important areas that may arise. This is not without its risks and limitations; however, in general the interview will mostly be guided by a topic guide or interview schedule rather than be dictated by it.

For the purposes of this study, I developed an interview guide with the aim of encouraging participants to describe and outline their experiences. The development of the interview guide was a gradual process. It was developed over a period of time and was devised based on discussions with my academic advisor and on informal conversations I had with colleagues and other researchers in the area who had an interest in the topic. The guide was also informed by the literature and my own experience as a nurse working specifically with asylum seekers. Overly long at first, it was amended to include key questions that I used as a check list to determine if participants did not raise issues spontaneously (see Appendix D***). Specific domains of enquiry were established using a number of open-ended and some closed questions. I hoped that the semi-structured interview guide would facilitate comfortable interaction with participants and that it would allow them to discuss issues of importance to them and produce detailed accounts of their experiences.

Using the interview guide, my introduction to each interview was relatively standardised. I explained the purpose of the guide and this appeared to have the advantage of reassuring the participants and easing any apprehension they had.

Firstly, it allowed me to introduce myself and thank the interviewee for attending, while explaining in brief the purpose and background of the study and some background information about myself. The interviews also provided an opportunity for assurances of confidentiality and anonymity. The guide allowed me to focus on issues of particular importance to the research questions and to probe and clarify comments made by the interviewees, while simultaneously allowing them the freedom to address issues that they considered important (Robson 2002, Silverman 2010). In this context, Smith and Osborn (2007) acknowledge that the respondent can be perceived as the experiential expert on the subject and should therefore be allowed maximum opportunity to tell their own story.

The interview guide was intended to be non-directive to some extent and over the course of the interviews I learned, where appropriate, not to direct the interview and to let each interview take its own unique direction so as to ensure the interviewee felt relaxed and comfortable. They could then express themselves freely with minimal interruption from me. Although the interview guide provided some reminders, the interviews unfolded in directions that I could not have anticipated, proving insightful and valuable at times. Although I found this challenging, I encouraged participants to share their experiences and I used more directional questions to encourage participants to elaborate on what they were saying and not to elicit agreement or disagreement on particular statements.

Those who consented to interview requested that their interviews be conducted in their place of work i.e. local health centre and at a time that was convenient to them. In addition, it provided a convenient and familiar environment for interviewees allowing them to feel comfortable with their surroundings during the interview process. It has been suggested that research interviewers should adopt a relaxed atmosphere and polite manner to put participants at ease and to be non-judgemental (Robson 2002, Silverman 2010). All interviewees agreed and consented to have their interviews recorded, as was outlined in the participant information sheet they had received (see Appendix B). I took field notes for all of the interviews in order to assist with the transcription and re-checking of facts and information with the interviewee, if necessary, at a later point. I noted things like body language, discomfort, pauses, inconsistencies and any external factors like interruptions.

The nurses needed to feel comfortable with their use of language in order for the interviews to proceed and for data to emerge (Lobiondo and Wood 1995, Robson 2002). The interviews revealed that nurses were hesitant, uneasy and at times embarrassed by their unfamiliarity with terms used in the cultural diversity discourse. During the course of interviews, some nurses sought direction and clarification by asking direct questions of me by means of reassurance and approval on the use of terms. However, throughout the interviews I responded to the interviewees in a non-judgemental way by reassuring them and encouraging them to use whatever terms they would normally use when describing their experiences to colleagues or within the work place.

In hindsight and on further reflection, from reading and re-reading the transcripts I wondered on balance if I should have provided participants with a glossary of terms to assist with the interviews. However, this would have unduly influenced their responses and perhaps disabled their freedom of expression and personal descriptions of their own accounts. As I was possibly considered an insider researcher, I was also reluctant to interfere in a way that would have negatively affected participants' engagement with me and the research process. I found this a difficult and an uncomfortable experience from a professional and ethical standpoint.

Having started the interviews and acknowledged my lack of experience, I found it useful to apply the Gibbs Reflective Cycle (1988) as a method of helping my own reflexivity. I noted my observations, thoughts, feelings and actions in the reflective journal I used throughout this study. This helped me to prepare in advance with more confidence for undertaking subsequent interviews. While this was time consuming, it allowed me to consider the interview process and my ethical position as researcher. It resulted in practical improvements such as better time-keeping and allowed participants to speak uninterrupted. It also allowed me to consider methodological and theoretical perspectives on the research process and alerted me to improving facilitation of rapport and empathy with respondents. Being comfortable with flexibility enabled the interview to go into novel areas that produced richer data than I had originally anticipated. It also allowed me to flag up potential places where my personal bias might influence how I analysed participant data.

However, participants were sometimes confident and forthright in the opinions they expressed in relation to their transcultural experiences. During the interviews it became apparent that many participants used the interview as a space in which to reflect on their work and to talk about personal and professional incidents and experiences. It became evident that these views had been forged in challenging circumstances and some were reflecting on and recounting issues for the first time. This made their accounts all the more interesting because of the resilience, strength and courage they had developed in the face of obstacles they encountered in the community nursing context. I could relate to these aspects in an empathetic way that the participants shared. In conducting the interviews, it allowed me to recall my own thinking and learning over time and to acknowledge how, in my current role, I too

built resilience and courage out of ignorance and reflection on experiences. However, some contradictions and inconsistencies would also emerge through the participants telling of their accounts in both positive and maladaptive ways. This became clearer throughout the process of analysing transcripts and will be outlined later in the analysis and findings.

Interviews lasted approximately 45 minutes to one hour and at the end of each interview I thanked participants and asked them if they had any questions or comments on the interview. The feedback I received from participants about their participation in the interviews mostly concerned their sense of being unable to adequately articulate their thoughts and experiences.

As the interviews progressed, I applied myself to the interview process with an increasing awareness of my own subjectivity and bias in an effort not to influence the responses of participants. As I work fulltime in a multicultural healthcare context, the recordings showed that in a couple of early interviews, I occasionally found it difficult to remain neutral and non-responsive when interviewees disclosed information on matters familiar to me or on issues I felt passionate about. I found myself appearing to agree or disagree. These occasions required an acknowledgment and naming of my bias and explanation and clarification of my position.

I found this aspect of the interview process warranted a further level of self-reflection and knowledge and was something I could have been better prepared for. However, although I tried very carefully in subsequent data collection to avoid showing any bias, I felt more able to explore alternative explanations with participants.

Van Manen (2007) cautions researchers on this possibility stating that;

“ ...one needs to be oriented to ones questions or notion in such a strong manner that one does not get easily carried away with interviews that go everywhere and nowhere” (2007, p.67).

As the nurses were interviewed in their workplace, this also resulted in some practical difficulties at times. Due to clinics operating in rooms close to the interviewing room and because of poor sound proofing, two interviews were interrupted because of

background noise. These were terminated and continued in another more suitable and quieter room. This resulted in some interruptions of thought and conversation and resulted in slightly lengthier interviews than had been planned for. This required me to be patient, understanding and empathetic to the interviewees and also to be grateful for their time. Out of respect I needed to apologize for any inconvenience and assure interviewees they were not obliged to continue interviews that ran over time. Subsequent difficulties in hearing and transcribing of recorded data did occur with these two interviews. However, for transcription purposes, clarity on the content recorded was sought from the interviewees.

While much valuable and rich data was gleaned from the interviews; on reflection, as a novice researcher significant attention must be paid to the organised planning of the interview process. For example, from a pragmatic perspective, familiarity with the interview environment prior to the time of interviews so as to avoid possible interruptions and mishaps would have been advisable. From a methodological perspective the interviews provided a significant opportunity for reflexivity and consideration of my own position in the research process. This included how my own subjectivity and interaction with participants influenced my interpretations of the data and my experience of interviewing. I will apply this learning in undertaking future qualitative research. The following section outlines the process I undertook in transcribing the interview recordings.

Transcribing of Interviews:

All ten recorded interviews were transcribed verbatim by me. Where possible, interviews were transcribed as soon as possible after the interview with reference to the field notes I had taken during the interviews. All transcriptions were completed within a period of two months. The interview recordings generated a large volume of data - over one hundred and ten pages of transcriptions. Even though the transcribing process was time consuming and arduous, requiring clear concentration and active listening skills, it allowed me to remain close to the data.

As part of the transcribing process I played each recorded interview twice. The first time was to establish the quality of the recordings and to be alert for any inaudible flaws or technical problems. Each interview was played and listened to continuously

without any interruption. This also allowed for recollections and re-call of other relevant issues that arose during the interviews – e.g. interruptions.

The second time I re-played the individual interview recordings for the purposes of transcribing only. On transcribing each recorded interview, I listened and re-listened intently to gain a clearer understanding of the participants' experience and to remain familiar with the data. Once typed-up, the transcribed texts were page numbered sequentially. Each individual interview transcript was given a code that referred to the individual respondent as well as appropriately anonymised biographical data. This code was identifiable only to me as the researcher. All data, recordings and transcripts were kept safely and securely in accordance with data protection procedures and the ethical standards outlined to participants in the information sheet.

The transcribing process also enabled me to associate and recall feelings and memories I had experienced when undertaking the individual interviews. I found this triggered further critical thinking and informed the interpretative analytical approach I intended to apply.

Data Analysis

Having gathered data from the interviews, this phase of the study required a method of analysis that involved a reflective interpretative process in keeping with the original research questions and my chosen methodology. Just as there is no one single method identified for the methodology of interpretative or phenomenological research, there is no single method for data analysis (Fain 2004, Silverman 2010). Phenomenological interpretations derive their entire content immediately and continuously from the human experience. This involves the researcher developing a sustained engagement and interpretative relationship with the texts and transcripts and taking account of additional information recorded in the field notes. The aim of which is to extrapolate meaning and understanding from the content and complexity of respondents' experiences, in this case the transcultural experiences of community nurses in the work place (van Manen 2007, Smith et al 2009).

I decided against the use of computer assisted analysis of qualitative data (CAQDAS) for this study. I was conscious of my position in the research, as my motivations have influenced my choice of project, research questions, research design, methodology and interpretations. Nonetheless the rationale for this decision primarily centred on the following reasons. Firstly, my preference to obtain a closer connection and immersion with the data and an appreciation for the human experience of the research process as a whole. Secondly, the numbers of interviews undertaken for this study were of an appropriate number to permit manual analysis. Thirdly, computer software merely assists with analysis, as opposed to carrying out analysis.

I felt that human interpretative analysis would potentially make better sense of the data. By adopting this approach I remained cognisant of the danger of the 'deficiencies of human as analyst' and I acknowledged other limitations, for example, where information that is difficult to get hold of gets less attention than that which is easier to obtain. However, as qualitative interpretative analysis is inevitably a personal process, I wanted to proceed with this approach in an effort to present and create a deeper understanding of the ways in which participants experience transcultural nursing encounters in HSE Liffeside.

In applying this type of analysis I was aware that differing levels of interpretation may arise in my attempts to both describe and understand the phenomena I was investigating (Van Manen 2007, Smith and Osborn 2007). The initial stage of the process involved the isolation of themes and will be described in the following section.

Isolating Themes

I proceeded with the qualitative analysis of data from the interviews using an interpretative approach. The first step in this type of approach is immersion in the original data. All of the individual transcripts were read and re-read several times in order for me to become as familiar as possible with the accounts of participants. I focused on actively engaging with the data and found that this repetition, although time consuming and laborious, gave me a clearer sense of the experience of the interviews. I found that keeping the participant's voice in mind gave me a more

complete experience of the data analysis. It also helped to develop an understanding of how the participant's individual and collective narratives knitted together.

To assist with analysis, for purposes of description and understanding of the data, I matched each interview transcript to the respective field notes I had documented. Each reading had the potential to throw-up new insights. During this process I annotated what seemed interesting and significant about what the respondents said. This allowed me to re-call individual participants and their interview experiences, including nuances and non-verbal queues that I had noted.

On first reading the individual interview transcripts, I observed that a number of type of terms, statements and phrases used by participants in the extracts, although not verbatim, were remarkably similar. Some of these were shared across and between participant's transcripts and others were individual. Some were mentioned less frequently while others were mentioned and discussed more often. As anticipated, some parts of the respondents' narratives were richer than others.

These accounts contained a lot of descriptive and rich information and were clearly matters that participants regarded as significant and had freely chosen to discuss. This necessitated further exploration and reflection by me.

At this stage I began highlighting the terms, phrases and statements that stood out for me and seemed to be illustrative of the nurses' work-based transcultural experiences. This selection or highlighting approach (Van Manen 2007) of isolating thematic statements involved listening and re-listening , reading and re-reading the accounts many times and asking: What statements or phrases seem particularly essential or revealing about the phenomenon or experience being described?

At this preliminary stage I found myself making associations within an interpretative understanding. When reading and recalling accounts, I found myself moving from the descriptive to the interpretive as I progressed from the particular to that which was shared among cases and I began charting connections, patterns and interrelationships between my initial notes and the participants' transcripts.

Van Manen (2007) reminds us that a so-called thematic phrase or phenomenological theme is much less a singular statement than a fuller description of a lived experience. Moving through the transcripts individually and collectively, I also found myself commenting on similarities, contradictions and differences that were beginning to emerge from people's accounts. For example, I found myself commenting on the use of language by the participants and considering how this may influence their sense of themselves in response to the research topic and their experiences.

In identifying emergent themes, I focused on discrete sections of transcripts including my noted comments and I began to take a more central role in organising and interpreting the material. I generated concise statements that were reflective of specific sections of the participants' transcripts.

By refining, grouping and re-grouping particular statements and phrases, I began searching for connections within the descriptive accounts and exploring how these statements fitted together, looking initially for patterns within individual transcripts and then across all cases.

I highlighted, documented and codified these statements and phrases and gave them emerging themed titles. The process of looking for patterns in themes from all ten transcripts led to the emergence of a number of overarching themes which subsumed lower level themes. I began to list the emerging themes chronologically from the individual transcript accounts based on the patterns of recurring themed statements and phrases including key words across individual and collective accounts (See Table 2: Key themes and sub-themes)

In deciding which themes were to be considered key essential themes as opposed to minor non-essential themes (but nonetheless important), I referred back to the transcripts to re-check the themes against the statements and phrases.

This required careful attention and a systematic approach. By bringing these together it allowed me to highlight what I understood to be the more interesting and important aspects of participants' accounts. By identifying key themes I began to abstract a level of meaning and understanding in the context of the research topic and my own

experience. In doing so I also attempted to remain aware that, despite some distance from the text, I was to continue to be closely engaged with the lived experience of the participants' accounts (Smith et al 2009, Van Manen 2007).

As an insider researcher, I first attempted to stand in the shoes of the participants. I could relate closely to the rich descriptions of their experiences and I valued this. However, as the researcher I was also aware of a need for me to reflect and critically interpret accounts and build an alternative excerpt that differed from that of the participants. Although the primary focus of my approach was the meaning that participants make from their lived experiences, my interpretations resulted in an account of the ways in which I believed participants were thinking.

For example, I began to think that due to my position as a clinical nurse specialist, working specifically with asylum seekers and refugees, I was aware that participants may have perceived me as an expert in the field and some participants may have interpreted my involvement within a managerial nursing context. Consequently, my thinking was that some participants, so as to avoid descriptions and feelings of inadequacy or un-professionalism, portrayed accounts of being stoic and willing to 'go it alone' and manage this type of work independently rather than seek out direction and support, as this may have been interpreted as weakness on their part.

Although I could relate very well to their descriptive accounts, on further reading of the transcripts, I wondered if the participants were telling me what they thought I wanted to know or hear. In recalling and reflecting on their accounts, I considered if nurses may have felt embarrassed or ashamed to admit that they were unfamiliar with specific aspects of caring for migrants and working with culturally diverse clients. For example, their apparent lack of knowledge of appropriate terminology and the influence of this on their interest or motivation to self-reflect and change attitudes and practices. Of course, I could understand that participants did not want to let themselves down by showing genuine ignorance; however, from my perspective as the researcher, I needed to extrapolate further meaning from such accounts.

Ultimately what developed was a dialogue between myself, the coded data and an understanding of the participants' experiences. By focusing on participants' points of

view and on participants' meaning in specific contexts, the analysis became inductive, resulting in a close analysis of each participant's account that identified emerging patterns or themes. At first this occurred based on individual cases and then developed collectively across multiple cases. By remaining close to the original data through reading and re-reading, an excerpt developed from the extracts that guided me as the researcher through accounts that resulted in some degree of convergence and / or divergence at times.

For example, although I had selected participants on the basis of some different characteristics, I found that many participants' accounts contained a similarity in their portrayal of their transcultural experiences in Liffeside. Participants who had worked overseas and those nurses working a lengthier time in Liffeside, described similar levels of frustration and demonstrated a common lack of motivation and knowledge in proactively addressing communication barriers in the nursing service. As the researcher, I found myself asking further questions to assist in my analysis of these accounts. For example, why did individual nurses who were experiencing similar problems in the same location not seek individual or collective solutions?

Therefore, through the interpretative approach I had to consider other ways of thinking. Perhaps it was that nurses were not intentionally creating barriers but were instead working in ways they had been socialised into? Or did they simply not care about intercultural communication, as they knew that to implement appropriate change in practice would involve more time and asking for help from seniors and management? Would this draw attention to what may have been considered inequitable levels of practice in the community service? Or perhaps if they did manage to communicate effectively could it mean more work and involvement with families / clients they did not feel comfortable or resourced to work with?

For me as the researcher using this interpretative approach, I found myself at times asking more questions than finding answers. Although I learned to accept that a critical approach was an essential component of the analysis, I found this aspect frustrating and demanding at times. On reflection it raised questions for me about my own practice and my approach to working with cultural diversity and challenged my own ethnocentrism and cultural impositioning. In addition, through the research

process I began to question my own practice and role up to this point and to consider whether I was contributing to this inertia at times by not engaging more systematically in a supportive way on transcultural nursing issues with the wider community nursing service. This development process was essential for me, and enabled me to proceed with a clearer understanding of my role as an insider researcher. More importantly, as I proceeded, it helped me to understand participants' experiences more clearly.

Interestingly, I found that as I engaged in the process over time, the analysis of transcripts also made it possible to extrapolate some understanding from what was not blatantly expressed in participant's accounts. I found myself questioning and interpreting 'what was not being said'. For example, although the term racism was not explicitly mentioned by participants until prompted by me, on reading and re-reading the accounts, I began to identify thematic statements that became more evident and indicative of a racist paradigm. Through the process of highlighting, codifying and clustering particular statements and phrases that reoccurred in patterns between and across individual and collective accounts and through deductive reasoning of the use of language by participants, themes emerged that required further interpretation. What emerged was a key theme of 'Racism' with related sub-themes such as 'tolerance and change' and 'reluctance to name racism'. Similar to the previous example of communication, the interpretative approach required further critical questioning by me. In undertaking interviews and de-coding descriptive accounts about working with ethnic minorities it became clear to me that an obvious gap was present. For example, why were participants reluctant to mention racism in the first instance? Were they conscious of this omission? Did this emerging theme indicate blatant racism or was it unwitting and inadvertent? Some of these points will be addressed later in the discussion.

Throughout the research process I became conscious of my subjectivity but never more so than during this analytical stage. At times I found it difficult for myself as the researcher to detach from myself as the nurse working with asylum seekers. I was often faced with the same experiences as those I was interviewing. From my work in the refugee centre I was aware that nurses were working hard in the community nursing service to deal with the changing demography. I was conscious that the

change in population had occurred over a short period of time and nurses had struggled to adapt. In particular, as the researcher in this process, I found myself being in the privileged position of being able to step ‘outside’ and reflect on my own learning and my work-based role, confident in my knowledge of the subject matter yet relating and connecting to the encounters and learning occurring as part of the research process with the participants.

However, I was equally conscious that the change had occurred over the past ten years and that this time period should have presented opportunities for reflection and solutions by participants. Consequently, I began to reflect and question what I perceived to be some level of inertia within the service and nurses’ motivation to improve and resource their practice.

In wanting to acknowledge and minimize my influence on the outcome and presentation of the findings, I discussed the emerging themes with my academic advisor, project consultant and some of my work colleagues. On reflection, the themes appeared to correspond with some of my own experiences and understanding of cultural competence in the work-based context and also of that of accounts outlined in the literature.

What follows is an example from the original data used to illustrate the type of analysis undertaken as part of this study. The example refers to a question posed by me (R) about working with culturally diverse clients and the subsequent response being an excerpt from the participants’ transcript (P2),

R: When working with culturally diverse service users how does your own culture influence your practice with clients?

P2: *“When people say ethnic minority I don’t know if it is a great word to say or not. I don’t know what you should say really. Now I think they mostly would prefer to be known as New Irish. Would they? Maybe that’s what we should be calling them, not an ethnic minority. But also they want to keep their own culture. They have a lot of values in their own culture. You’re only going to alienate them more if you do that. Maybe say Middle Eastern background or African. Yeah just say the term. Say what they are. I don’t know”.*

On initial reading of this excerpt the use of language used by the participant (P2) demonstrates an uncertainty and ambiguity about how she herself relates to her experience of working with cultural diversity. In the first instance, there is a palpable sense of hesitancy and perhaps anxiety in responding to the question. When analysing the account, I was conscious of the interpersonal aspects associated with the interview and my own position. It is understandable that within the context of seeing me as a nurse specialist or manager that she would respond in that way. I considered that perhaps some embarrassment may have influenced her response and that she was also nervous. I also sensed an element of positive research bias whereby the respondent may have wanted to create a good impression. However, my interpretations would require further analysis.

For example, I attempted to move beyond my understanding of the participant solely in the interview context. I considered that the nurses in this research study were not just nurses working in an isolated bubble in Liffeside. The participants were active members of society who would ordinarily present and behave in a manner considered to be politically correct so as not cause offence to myself or others. They were not immune from influences of the media and other social elements and therefore I anticipated this.

By re-reading and recalling my own experience of the interview and referring to my notes, I observed particular emphasis by P2 on her use of language and using particular terms. I began to observe this throughout her transcript. For example, in her descriptions of her experiences when referring to clients, phrases and statements such as *'they'* *'them'* *'New Irish'*, *'ethnic minority'* tended to reoccur and formed a pattern throughout her narrative. As the researcher I needed to consider other influences and possible reasons for her describing her experiences in this way and the subsequent meaning associated with her use of language. However, this was not unique to P2 as similar descriptions and language were used by all informants.

When reading participants transcripts, I noted the recurrence of key phrases and statements across and between participants' accounts and descriptions. By re-reading

and identifying these phrases and statements, I began to highlight, cluster and regroup them under key themes and sub-themes.

In the above excerpt, the use of the terms, phrases and statements (underlined) by P2 may demonstrate a genuine lack of knowledge or ignorance of the terminology used in the social and political discourse of cultural diversity. P2 is hesitant and does not want to cause offence by using incorrect, or what she perceives to be offensive, terms. She is also seeking clarity and confirmation from me in the process. Although this is in some way to be commended (as the interview is also a two way learning street), she may have perceived me as an expert in the field and her seeking clarity may just be for the purpose of the interview. Nonetheless, it is apparent that clarity on terminology and its use in the professional context when working with cultural diverse clients has been lacking. However, in attempting to reach some further understanding, I considered that the descriptive account outlined may also be the result of an inadvertent level of discrimination or unwitting prejudice. This could be interpreted as a level of unconscious cultural competence and became more apparent to me in the process of reading across other transcripts. As I analysed participants' accounts I noted this as an emerging collective narrative. It did not appear evident to me during the interview process. However, from reading and re-reading the transcripts I observed the use of language by participants when describing and recalling accounts.

For example, further interpretation of this excerpt demonstrates a hesitancy to use first person statements in describing her own experiences, e.g., "people" "you're", "you". Although the participant portrays a willingness to engage with ethnic minority service users, analysis of the account, particularly in the context of language, demonstrates a social and psychological distancing. Perhaps it is an unconscious attempt to remove herself from being or feeling complicit in any type of social exclusion. Indeed it may also be a type of protective mechanism used within her nursing practice where she is unconsciously and unreflectively engaging in emotional labour.

Although P2 may not have wanted to give a negative impression, her use of language suggests that she was perhaps tolerant rather than accepting. Initially my understanding of this emergent theme suggested that P2 and other respondents were

trying to sound inclusive but as I engaged with the dialogue and observed patterns and interconnections across accounts, the way that language was used suggested the notion of ‘othering’. This led me to the development of a sub-theme ‘*tolerance and change*’, positioned within the overall key theme of ‘racism’.

What developed throughout individual transcripts were interconnected patterns stemming from the use of thematic phrases. Again, in the excerpt above, my interpretation resulted in the emergence of a further key theme ‘focus on difference’. From the outset, the participant perceives clients from other cultures as different, again closely related to ‘othering’. In this example, what emerged from further analysis of the recurring thematic statements within the overall transcript, was that a clarity evolved, identifying a related sub-theme which I termed ‘*inadvertent ethnocentrism*’.

The transformation of key phrases / thematic statements into theme titles (headings) continued throughout the whole transcript(s). As I expected, in addition to interconnections and similarities, some contradictions and paradoxes were also evident. The above excerpt (P2) alone demonstrates the complexity of interpretations inherent in the descriptions and narratives outlining participants’ experiences. For example, the use of language in the above extract also demonstrates other meanings and understandings. Perhaps a sense of not feeling ‘*supported in the work place*’ and having to ‘*learn on the job*’ - both of which, through closer interpretative analysis, became emergent sub-themes within the key emergent theme of ‘**professional preparation and support**’. P2 is seeking answers to questions and clearly acknowledges that she does not know – ‘*I don’t know*’. The extract demonstrates that there is some level of ‘*reflecting on practice*’ by the respondent, a theme that reoccurred throughout the transcript and other accounts.

In keeping with the interpretative approach, I considered descriptive, linguistic and conceptual aspects of the texts. I recalled the experience of the interviews and referred to my original notes and remarks. I chose statements that I felt expressed the essence of the majority of participants’ experiences. I was careful not to choose statements which I personally liked or disliked and I attempted to remain balanced in my portrayal of the emergent themes from the participants’ accounts. In the process I

retraced my steps constantly, re-checking themes that had already emerged and been grouped, against ones I considered to be emerging for the first time.

Although difficult to ignore and achieve at times, it was important to move away from the purely descriptive to a more questioning and abstract account. Of significant assistance to me at this point was the supervisory role of my academic advisor. Through the mentoring process I continued to reflect on my learning and my own subjective experiences of the research process and the emerging themes. Frequent return and reference to the literature throughout the process also helped to clarify my interpretations of the original data.

In generating themes I remained cognisant of the part in relation to the whole and conversely, the whole in relation to the part and hoped that the themes generated, reflected the participants' experiences and my interpretation of them (Van Manen 2007, Smith and Osborn 2007).

For illustrative purposes table 2 below outlines the key themes and sub-themes that emerged from the data. These will be outlined and discussed in further detail in the following chapter.

Table No. 2

Key theme	Sub-theme
1. Experiencing change in local population	<ul style="list-style-type: none">• <i>Rapid nature of demographic change</i>• <i>Patterns noticed over time</i>• <i>Local health needs linked to global health issues</i>
2. Racism	<ul style="list-style-type: none">• <i>Reluctance to name racism</i>• <i>Challenging and responding to racism</i>• <i>Tolerance and Change</i>
3. Focus on Difference ‘They and Them’	<ul style="list-style-type: none">• <i>Using the ‘right’ terminology</i>• <i>Inadvertent Ethnocentrism</i>
4. Building Relationship and Communication	<ul style="list-style-type: none">• <i>Connecting with people</i>• <i>‘Getting-by’ communication</i>• <i>Using interpreters</i>
5. Professional Preparation and Support	<ul style="list-style-type: none">• <i>Learning on the Job</i>• <i>Support in the workplace</i>• <i>Reflecting on experience</i>

Chapter Five: Findings

This chapter outlines the findings from the quantitative and qualitative parts of the study. It commences with a presentation of data from the respondent profile section of the completed CCATs. The chapter then goes on to outline the specific findings on the overall cultural competence levels of respondents, as derived from the CCAT scores. Following that, some limited analysis is considered in the context of interpreting the CCAT quantitative findings. In the final section the qualitative findings from the semi-structured interviews are presented in thematic format, using selected transcript excerpts and quotes that are analysed using the interpretative qualitative approach.

Due to this being a local study, confined to a specific population and area, the data is not generalizable or representative of the overall public health nursing context in the HSE. Nonetheless the findings should be of relevance to other disciplines and primary care areas and support the need for further research.

Profile of research population

This section describes some of the characteristics and variables from the demographic profiles of the respondents CCATs. Some useful and interesting findings are outlined that may help to influence and impact the development of cultural competence. Overall, the survey revealed a relatively homogenous population of community public health nurses in Liffeside health service area. The following section outlines a number of these demographic variables. It is helpful to keep in mind that the characteristics and variables presented from the CCAT demographic profiles are not precise indicators of levels of cultural competence but nonetheless are of interest and significance to the local context.

Gender

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Female	24	100.0	100.0	100.0

Table No. 3

The above table (Table No.3) depicts the gender profile of the research population of this study. As is evident the study population consisted of 100% female respondents. The data reflects the very low number of males working in community public health nursing. Statistics from An Bórd Altranais 2010 (Irish Nursing Board 2010) demonstrate that only 6 nurses out of 3,214 Registered Public Health Nurses (0.1%) working in public health nursing in Ireland, are male. A possible explanation is that nursing disciplines traditionally considered midwifery (0.1% male) and children's nursing (1.5% male) (An Bórd Altranais 2010) as the appropriate skill mix for entering public health nursing (NMPDU 2006). Socio-culturally, up to relatively recently, it was not the norm for males to be offered or to undertake such studies.

Up to 2005, midwifery registration was a mandatory requirement for entry into public health nursing studies and a prerequisite to register and practice as a public health nurse. It is fair to say that institutional barriers prevented the entry of males into midwifery schools as they were predominately owned and run by Religious Orders of Catholic Nuns. Traditionally, nursing was encouraged primarily as a career for girls, educated and socialised through the parallel Catholic primary and secondary school education system run by many of the same Orders of nuns. These administered the nurse training schools and institutions / hospitals up to relatively recently (Yeats 2009). Although gender is not a specific indicator of cultural competence development or levels, gender plays a significant role in all cultures in terms of values, prescribed roles, expectations, attitudes and behaviours. This is also true of health and systems of healthcare within the cultural context. The lack of male representation in community nursing in the HSE requires further research in the context of developing cultural competence.

Religion

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Christian	24	100.0	100.0	100.0

Table No. 4

Religion plays a central role in the construction and application of socio-cultural norms that are valued and expressed by individuals and communities. Very often

religious beliefs form a significant component of how people deal with and understand health and illness (Leininger 1995, Helman 2007). The above table demonstrates that again all respondents (100%) in this study (n=24) identified as Christian. It is interesting that no other faith perspective figured in the population of community nurses in the area. Nonetheless, to a limited degree, this finding reflects the CSO national statistics for religion which account for Ireland's population having a 92% Christian demographic. Although the finding is not representative of community nurses nationally, in the context of this study it still raises questions. For example, can a homogenous nursing population provide care that includes an informed understanding of the diverse religious beliefs and practices that exist in Liffeside? Also, if as suggested by some commentators, that the diversity of the healthcare workforce should reflect the diversity of the communities they serve, then the specific context of gender and religious diversity within community nursing and the development of cultural competence requires further investigation.

Country of Birth

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid ROI	22	91.7	91.7	91.7
UK	2	8.3	8.3	100.0
Total	24	100.0	100.0	

Table No. 5.

As can be seen from the above table (Table No.5), the majority of respondents 91.7% (n=22) were born in the Republic of Ireland with only 8.3% (n=2) being born outside of Ireland, specifically in the United Kingdom. Again this finding demonstrates some degree of homogeneity in the countries of origin of the respondents. Interestingly, it differs significantly from the demographic change that has occurred within the professional nursing workforce in Ireland over the past decade. From 2000 – 2008 non-EU nurses accounted for 40% of nurses newly registered with An Bórd Altranais (Irish Nursing Board 2009) with a further 10% being of an EU nationality other than Irish. While the respondent rate for this study is too small to be representative of national nursing trends or to derive any generalisations, this finding does raise questions. What are the implications for the development of cultural competence if

there is an under-representation of international nurses working in community nursing? The inclusion of diversity within the nursing workforce in terms of nationality, ethnicity, religion, and cultural background has been recommended and has been proven to enhance the development of individual cultural competence of staff and the delivery of culturally competent services (Brach Fraser 2000, Taylor 2011, Office of Minority Health 2013). Although country of birth does not necessarily denote nationality, ethnicity or cultural background and is in itself not an indicator of cultural competence; alone or among other variables it can be an influencing factor in the development of cultural competence. It is clear that the homogenous make up of community nursing in this context requires further research beyond the scope of this local study.

Ethnicity

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid White Irish	24	100.0	100.0	100.0

Table No. 6

Ethnicity as a cultural marker holds significant meaning and understanding for most people (Kottak 2004, Bhopal 2007). How people view and respond to the world they live in, including beliefs and practices that impact upon their health and wellbeing, is very much tied to their ethnicity (Helman 2007, Papadopoulos 2006). Similar to the previous demographic profile questions, this question aimed to illustrate, in limited ways, if the population make-up of community nursing in the area reflected the growth of population in Liffeside. Acknowledging that ethnicity is often captured within an incomplete and limited positivist type of questioning, the findings in this category also reveal an equally homogenous group i.e. 100% White Irish (n=24). Although it is not possible from this study, to draw concrete conclusions on ethnic representation in community nursing services in general, the finding does present opportunities for further research on ethnicity in local nursing. Interestingly, those respondents born in the UK identified as 'White Irish' demonstrating the fluid and changing nature of ethnicity that occurs over time and suggests influence by other variables. As no formal system for the collection of ethnic equality data on health

services staffing exists, it is clear that further consideration of ethnicity and ethnic diversity in healthcare provision is required if it is to reflect the emerging and increasing diversity of communities (HSE 2008).

Overseas Nursing Experience

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	19	79.2	79.2	79.2
No	5	20.8	20.8	100.0
Total	24	100.0	100.0	

Table No. 7

The participants were asked to declare if they had experience of working overseas (outside of Ireland). This was inclusive of either having trained as a nurse or worked as a nurse in a country other than Ireland. As many other factors contribute towards the development of cultural competence it must be acknowledged that overseas experience is not a precise indicator of cultural competence levels. Nonetheless, it can be an influencing factor in the acquisition of culture generic and culture specific knowledge and experience (Leininger 1995, Papadopoulos 2006).

79.2% of respondents (n=19) had overseas nursing experience (Table No.7). Although this local finding does not represent the level of overseas experience of community nurses in general, it does reflect the historical nature of Irish nurse migration trends. It is universally acknowledged that Ireland has a significant and well established tradition of nurse migration - particularly nurse emigration (Yeats 2009, Ryan 2007).

The findings in this study indicate that of those nurses who worked overseas (79.2% or n=19), 89 % of them had spent between 1 year and 6 years working outside of Ireland. The remaining 10% had spent over 6 years working someplace other than Ireland. All of the respondents outlined where they had worked, the vast majority having worked in the UK (n=10) and Australia (n=11) with some having worked in more than one country, including roles in overseas development aid in the Developing World. These demographics reflect in a limited way the data from the Irish Nursing

Board (2009) that show the UK and Australia continue to be the top two countries where Irish nurses migrate to.

There is an inherent value and benefit to be gained in terms of the social and cultural experiences that can evolve as a consequence of nurse migration (Taylor 2009, Chenowethm 2009). For example, positive outcomes such as bilingualism or the acquisition of culture generic and culture specific knowledge and skills (clinical, technical, social and cultural) can be gained by nurses personally and professionally. These professional overseas experiences are often overlooked as valuable factors in developing cultural competency skills. Further research, beyond the scope of this study, is warranted to investigate the possible benefits of utilising the experiences and shared learning of nurses who have worked overseas in the development of culturally competent nursing services.

Having briefly considered some of the respondents' personal characteristics, the following sections will briefly outline some of the professional ones that contribute towards the development of cultural competence in the local context. These include professional role, qualifications, length of time working as a nurse, and the length of time working in the research site.

Role in community nursing

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Community RGN	1	4.2	4.2	4.2
RPHN	21	87.5	87.5	91.7
Other	2	8.3	8.3	100.0
Total	24	100.0	100.0	

Table No. 8

The above table (Table No. 8.) lists the specific roles of the research respondents in their community care context. Although limited in defining roles based primarily on their employment as an RGN or RPHN, it illustrates to some degree the changing nature of the community public health nursing sector. It shows that there is an increasing skill mix evolving in response to meeting the healthcare needs of communities (Brady2007, Nic Philbin 2010). RGNs ordinarily conduct clinical

aspects of care in the community such as wound care management / tissue viability, whereas the RPHNs continue to maintain the more traditional aspects of their roles, mostly in the context of maternal and child health and areas of supervision and managerial responsibility. While the majority (n=21 or 87.5%) of the respondents were registered public health nurses, 12.5% of the nurses were practicing in a role other than that of a registered public health nurse. This may include working as a registered general nurse, registered midwife or nurse administrator / manager.

Although not generalizable, this finding corresponds with a review of public health nursing in Ireland that identifies an emerging trend towards a shift in service provision by public health nurses into new areas of responsibility including health visiting to asylum seeker accommodation centres (Office of Nursing Midwifery Service Director 2012). However, it is noted that there remains a significant dearth of qualitative empirical research stemming from the public health nursing discipline in this regard. Although a localised study, it is anticipated that some of the findings here may inform and encourage further investigation into changing roles for community nurses in the context of developing their cultural competence.

Post Graduate Qualification

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	higher Diploma	15	62.5	65.2	65.2
	Masters	4	16.7	17.4	82.6
	Other	2	8.3	8.7	91.3
	None	2	8.3	8.7	100.0
	Total	23	95.8	100.0	
Missing	System	1	4.2		
Total		24	100.0		

Table No. 9.

The above table No.9 on postgraduate qualifications and skills also demonstrates the increasing staffing and skill mix of the community nursing sector in the context of this study. A broad skill mix within the group of nurses working in the area was evident.

The findings demonstrate a high level of postgraduate professional education amongst the nurses in this local area. 65.2% (n=15) of the respondents to this question indicated they had a Higher Diploma in Nursing, relating primarily to the Higher Diploma in Public Health Nursing qualification. In addition to the higher diplomas in public health nursing there is evidence of further studies undertaken by nurses in areas such as post-natal depression, child welfare and protection and health care management, including four nurses (n=4 or 17.4%) with Masters degrees in nursing or a related field such as healthcare management. Other higher level awards in specific clinical areas were also mentioned by participants and it is clear that nurses other than public health nurses are being employed in the community nursing setting in an effort to meet the healthcare needs of a changing society. It also illustrates a commitment by nursing management to supporting change and diversification of the nursing service to meet the needs of the community. However, further qualitative investigation beyond the scope of this study is required to extrapolate the extent and use of the various skill mix and types of education and the corresponding application to nursing practice in the Liffeside area.

No. of years working as a registered nurse:

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 6-10yrs	6	25.0	25.0	25.0
11-15yrs	5	20.8	20.8	45.8
16-20yrs	2	8.3	8.3	54.2
Over 20 years	11	45.8	45.8	100.0
Total	24	100.0	100.0	

Table No. 10

No. of Years working in the research site:

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1-5yrs	13	54.2	54.2	54.2
6-10yrs	8	33.3	33.3	87.5
11-15yrs	1	4.2	4.2	91.7
16-20yrs	1	4.2	4.2	95.8
Over 20 yrs	1	4.2	4.2	100.0
Total	24	100.0	100.0	

Table No. 11

The above tables, No. 10 and No.11, illustrate the total number of years of work experience as qualified nurses and the number of years working in the research site. While not an indicator of cultural competence, this finding combined with the previous findings on skill mix, demonstrates that the participant group is comprised of experienced nurses. 54% (n=13) of the respondents had been working as qualified nurses for between sixteen years and over twenty years. Of the total group 49% (n=11) had been working in the area for between six and twenty years. Consequently, most of the nurses had experienced some of the recent population and cultural demographic change in the Liffeside area. However, as the CCAT was limited in its ability to interrogate the in-depth experiences of nurses during this time, further exploration using qualitative methods was undertaken and will be described at a later stage in the qualitative methods section.

CCAT: Cultural Competence Levels of Participants:

The use of the CCAT in this study provides some limited opportunity to consider the cultural competence levels of nurses. It also helps to raise questions for further interrogation with qualitative methods which will be considered later in this chapter. As outlined previously the CCAT was employed for the gathering and analysis of baseline data and was intended only as an indicator rather than an objective assessment of cultural competence.

All of the returned and completed CCAT score sheets (n=24) were entered into the CCAT computer programme for analysis. The allocation of cultural competence practice levels were determined and generated by the CCAT software. The results were as follows:

Level of Cultural Competence Practice	No. of Respondents
Cultural Incompetence (CI)	0
Cultural Awareness (CA)	24
Cultural Safety (CS)	0
Cultural Competence (CC)	0

Table No. 12

The CCAT computer analysis returned all 24 respondents with a cultural competence level of '***Cultural Awareness***'. Although nobody was deemed culturally incompetent, this is still a low operational level of cultural competence. Also, as none of the participants were deemed to be culturally safe, the finding necessitates some further analysis and explanation within the local context of the study. As the research population was small I undertook some limited analysis of each CCAT to determine validity of the findings. For example, where comments were made by respondents on the CCATs, these were noted and subsequently informed a limited analysis of the quantitative data. As this was a limited local study and the population was small, any comparative analysis using variables would have been statistically insignificant and inconclusive. In addition, they were not suited to drawing any verifiable conclusions and/or generalisations. Therefore cross-comparisons between respondents CCATs were not undertaken within the scope of this study.

The following sections outline some of the findings from each of the four domains of the participants' CCAT surveys. Although mostly descriptive with limited analysis, it attempts to demonstrate some evidence of the stages of cultural competence development of the participants.

Cultural Awareness Levels

According to the CCAT criteria, cultural awareness is the prerequisite for achieving cultural competence and a score of less than 5 points in the cultural awareness section automatically confers a level of cultural incompetence. In this study no individual was categorised as culturally incompetent as all scores in this domain ranged from 5 points to 10 points. The findings from this section of the CCAT are based on the statement scores for cultural awareness and indicate high levels of individual cultural awareness by the respondents.

75% (n=18) of respondents scored a level of between 8 and 10 points in the Likert scale on culture generic and culture specific statements. This included 42% (n=10) of research respondents who scored the maximum score of 10 points on the statement scores.

When the CCAT statement scores are compared to the subjective self-assigned visual analogue scores (VAS), the findings reveal a slightly higher incidence of overall cultural awareness with 83% (n=20) of participants scoring themselves between 8 and 10 points. Interestingly, on the VAS scale, a lower number of respondents 25% (n=6) scored themselves the maximum number of 10 points. It seemed that respondents assigned mixed understandings of cultural awareness and appeared to question their confidence with regard to their own perceptions of their cultural awareness. For example, 38% (n=9) disagree with the statement A5 i.e. *“ethnic identity changes with time and the influence of wider social factors”*.

While it remains significant in this study that no nurse was deemed culturally incompetent as per the CCAT criteria, it is not surprising that nurses would want to score themselves highly in cultural awareness. The findings here raise further questions in regard to the development of cultural awareness in individuals and how this may evolve and strengthen their cultural competence development.

For example, the findings may suggest that nurses are unaware of the theoretical understandings and the social construction of ethnicity and ethnic identity and its relevance to their professional and personal lives. Indeed it may also be a question of comprehension and understanding of the terminology and language used in the field of cultural competence and equality studies. It may be that the terminology used in the cultural diversity discourse and included in many of the questions may have been unfamiliar to nurse'. For example, terms used throughout the CCAT such as *'folk systems'*, *'minority ethnic groups'*, *'cultural assessment'*, *'institutional racism'* and *'ethnic identity'* were possibly being considered and reflected upon for the first time in a professional context by many of the nurses. However, some further explanation is also required as the majority of nurses were working in the area for a considerable length of time.

Although for the most part the majority of nurses appear to tick the 'right' answers, limitations of the tool must be borne in mind. As with any quantitative type survey, there may have been an element of chance in ticking answers without much consideration or thought. The CCAT is a quick screening tool and in this instance was being used for the first time with the respondents. Similarly, it is likely that nurses in

this study were not aware of the meaning or significance of the use of the culture specific and culture generic statements in the context of healthcare provision, possibly due to the lack of attention this area receives within the Irish health service.

Another limited explanation of these mixed results on cultural awareness may be attributed to some of the findings from the participant profile section of the study as outlined earlier. Even though nurses are experiencing diversity within the community of service users, the homogenous and mono-cultural nature of the nursing population may not be challenging them to reflect openly and honestly on diversity issues amongst themselves. This raises further questions such as; ‘Why are there no nurses of non-Irish, Black and/or ethnic minority background working in public health nursing in Liffeside?’ or ‘Are nurses missing out on opportunities to form meaningful professional relationships with culturally diverse healthcare colleagues, and if so, what are the implications of this for the development of cultural competence within the service?’

Nonetheless, what is demonstrated from the comparison of both types of CCAT measurement (statement and VAS scores) is a slight discrepancy and contradiction in how nurses rate and understand their own cultural awareness.

The CCAT has been useful in providing a baseline of descriptive data regarding cultural awareness but has not allowed for qualitative exploration. This is worthy of further qualitative investigation and some of this incongruity will be considered in the discussion of findings at a later stage.

Cultural Knowledge Levels:

This part of the CCAT (cultural knowledge) primarily relates to investigating respondents levels of knowledge about influences and conditions that can positively or negatively affect the health of ethnic minority clients. These include health care provision, access and delivery of appropriate services. An important element at this stage of the CCAT assessment is attention to the type of knowledge nurses need to assess clients, such as clinical transcultural knowledge. Examples include disease patterns (epidemiology), presentations based on cultural beliefs and incidence of health care disparities in and amongst ethnic minority groups. Again using objective

statement scores and self assigned VAS scores, the CCAT data revealed varied but limited levels of cultural knowledge amongst the nurses. Interestingly but unsurprisingly, scores in this area were lower compared to the other domains.

For example, just 50% of respondents scored in the higher end of between 8 and 10 points which included only two respondents (n=2) or 8.3% scoring the maximum 10 points for cultural knowledge. Of note in the CCAT responses was the fact that statements pertaining to more clinical issues revealed lower levels of cultural knowledge and uncertainty among the respondents. Interestingly, the comparison between the statement scores and self-assigned VAS scores also demonstrated uncertainty and a lack of confidence in cultural knowledge. I will consider why this may be so later in this section.

For example, in response to statement B8, *“High blood pressure is more common amongst black people than the white population”*, a clear split exists between the respondents. 42% (n=10) agree with the statement and 54% (n=13) disagree with one non-response. On another clinical cultural knowledge statement, a larger divide was evident. In response to statement B10, *“Coronary heart disease is more common amongst people of South Asian communities than the white population”*, 71% of respondents disagreed with this statement.

Similar to the findings outlined from the previous domains of the CCAT, the cultural knowledge findings also revealed some inconsistencies and contradictions. This is of significance in the context of the stage where nurses tend to be at in the overall development of their cultural competence. For example, in considering cultural knowledge 37.5% (n=9) of respondents disagreed with statement B5, *“people from minority ethnic groups have particular difficulty in accessing health services”*, yet a unanimous agreement of 100% (n=24) of respondents agreed to statement B9 that stated, *“it is important to acknowledge particular cultural beliefs and practices in relation to delivering public health activities to minority ethnic groups”*.

When it came to self-rating, 58.3% (n=15) of respondents rated their level of cultural knowledge at level 6 or lower on the VAS statement B11, *“I am not at all informed about the cultural and social situation of the majority of my clients”* (lower values) or

“I am very well informed about the culture and social situation of the majority of my clients” (higher values).

It is difficult to interpret and understand these findings just through using the CCAT as the tool only allows for limited interpretation and fails to explain or test the superficiality of these responses. For example, respondents are not asked by the CCAT to express how inclined they may be to acquire cultural knowledge or from where they may source it. Consequently, an opportunity for exploration of motivational factors to acquire cultural knowledge could be considered and included as a further VAS statement (self assigned score) in the CCAT section on cultural knowledge.

Even so, it is apparent that gaps exist in the cultural knowledge of nurses. These may arise from a lack of professional development opportunities that include specific ways of learning and reflecting on practice. However, others may be more personal to individuals. For example, nurses who responded to the statements in this section may not be aware of their own unconscious direct and indirect prejudice and subsequent discrimination that can evolve inadvertently or indeed deliberately in practice. Although just 21% (n=5) of the respondents disagreed with statement B6, *“that discrimination and harassment in everyday life leads people to engage in behaviours which may be damaging to health”*, this finding is still worrying in the context of the delivery of equitable care by nurses to all people in the community. It raises further questions about how nurses are exposed to social thinking and opinions from media or locally, including from amongst themselves, relating to cultural diversity and if this influences their attitudes, behaviours or approaches to working with ethnic minority clients?

Attention must also be paid to the paucity of scientific data and published studies available on ethnic minority health within the Irish health context and specifically in public health nursing. Although primarily due to the absence of a national ethnic equality data collection system, the impact of a lack of information is bound to have implications for professional development and practice. Despite a body of scientific transcultural knowledge from the U.K., U.S.A., and elsewhere that is broadly applicable, nurses in this study appear to be quite insular in their efforts and capacity

to acquire the appropriate information. Even in the local context, if new knowledge is not being generated and discussed within the professional learning and work based environment, it could be argued that it is not therefore in the consciousness of nurses. However, although this may offer some explanation for low levels of cultural knowledge; this in itself should not to be used as an excuse to maintain the current status quo.

In the main, the findings from this section reveal that nurses do not ordinarily consider evidence based clinical, transcultural knowledge or the negative effects of types of discrimination such as racism on ethnic minority clients. At this point any attempt at interpretation of these CCAT findings is purely speculative and no generalisations can be made. The following section considers the next stage of the PTT model and what presented from the CCAT findings on cultural sensitivity.

Cultural Sensitivity Levels

By assessing levels of cultural sensitivity using the CCAT we can attempt to establish how health care workers view people in their care and consider the power relationships that influence healthcare encounters and subsequent outcomes. The literature has already explained how power can be enabling or disabling in the health professional -client dynamic. Therefore, by its very nature, in comparison with the previous domains, it is a sensitive and complex component to assess. Indeed the sub-constructs that inform this domain (within the PTT model) such as empathy, trust, respect and acceptance are core inter-personal traits that require significant attention to emotional and psychological processing. Therefore, assessing levels exposes the more human aspects of respondents, aspects that may make them feel more susceptible and vulnerable. Additionally, the development and application of cultural sensitivity requires effective communication with clients and this is often compounded in transcultural situations.

Similar to assessment in the previous CCAT domains, the statement scores for cultural sensitivity were compared to the VAS scores. Interestingly, a higher level of cultural sensitivity was scored by respondents in the self assigned category (VAS). For example, in the culture generic / culture specific statement scores, only 50% of

respondents (n=12) scored in the higher values (8 to 10 points) including only two (n=2 or 8.3%) scoring the maximum of 10 points.

Conversely, the findings also illustrate an incongruity among respondents between their actual levels and their own perceived levels of cultural sensitivity. When compared to the VAS self-assigned scores where respondents were asked to rate the statement C11, *“I’m very uncomfortable working with people whose beliefs, values and practices are different from my own” (lower)* or *“I’m very comfortable working with people whose beliefs values and practices are different from my own” (higher)*, 75% of respondents (n=20) scored themselves in the higher range with 7 respondents (n=7 or 29%) scoring themselves 10 points.

Of course it’s not unusual for nurses to want to portray themselves as sensitive, empathetic and trusting – even if they are not. In many respects this finding is unsurprising, as nurses do not want to be seen as insensitive in any aspect of delivering care. The high level of VAS self-scores may be due to participant bias where nurses were keen to demonstrate they are sensitive to the needs of all service users, including people from ethnic minority communities. In addition, it may also reveal a fear by respondents of being exposed as participating in discriminatory practices if they score themselves lower.

However, a fundamental component in developing and applying cultural sensitivity is effective communication. As cultural sensitivity is primarily a relational concept aimed at establishing a true partnership between the care giver and client, any deficit in communication, such as the lack of a common language, may impact the healthcare outcome. In addition, a reluctance to move from what Leininger (1995) describes as ‘Stranger to Trusted Friend’ may result in the creation of stereotypes and prejudices. Responses to statements in this section of the CCAT revealed interesting results in the context of cultural sensitivity and communication. For example, 37.5% (n=9) of respondents were in agreement to statement C1, *“it is almost impossible to communicate with a client who’s first language is not English”*.

This divergence may represent a limited understanding of the complexity of cultural sensitivity and its development and application by respondents. However, it does raise

some questions for consideration. Are respondents quick to judge or form a negative opinion about working with non-English speaking people or those for whom English is not their first language, without first exploring other factors? And if so why? Similarly, how can nurses establish effective culturally sensitive relationships with clients if they cannot communicate?

Effective intercultural communication is essential for the development of cultural sensitivity. It is evident from nurses' responses in this study that they recognise the need for practitioners to be trained in the use of interpreters with 92% (n=22) agreeing with the statement, while similarly 95.8% (n=23) agreed that interpreters and advocates need to be trained, in order to effectively represent the best interests of the client.

However, apart from structural barriers such as a lack of practical resources like access to interpreters or cultural mediators, other factors such as unchallenged negative attitudes or misinformed notions about client's values, beliefs and norms may impinge on the understanding and development of cultural sensitivity for healthcare staff. Interestingly, 75% (n=18) of respondents agreed that "*people from some ethnic groups can be very demanding*" indicating a level of stereotyping and prejudice that may influence nurses interactions with service users. Yet it is difficult to interpret this finding within the limitations of the quantitative approach of the CCAT. Consequently, more in-depth interrogation was warranted and will be discussed later in the qualitative methods section

It is clear thus far from the CCAT findings and the appropriateness of their responses that ambiguity exists for nurses in their understanding of the challenges faced by ethnic minority individuals and groups. The question must now be asked whether nurses can move on without questioning their own values or lack of knowledge and progress to the next stage of cultural competence development. Prior to considering this, the following section will outline some of the findings of cultural competence practice of the respondents.

Cultural Competence Practice Levels

The final stage in the development of cultural competent practice is primarily skill based (clinical, assessment, diagnostic). The amalgamation of all three domains determines the outcome of cultural competence practice. Of particular importance in this stage is the capacity of the health care professional to challenge and address inequalities, prejudice and discrimination.

In outlining findings from this domain it is important to note that as none of the participants were deemed to be at the level of culturally competent (according to the CCAT assessment criteria and formula), what follows here does not propose to be a detailed analysis of overall levels of cultural competence.

Despite none of the respondents achieving an overall level of cultural competence, this domain received the highest number of maximum points in the objective statement score section. 95% of respondents (n=23) scored between 8 and 10 points, including 13 respondents (n=13) or 54% achieving the maximum score of 10 points. However, when compared to the VAS self- assigned scores for cultural practice, all respondents scored their own perceptions of their cultural practice lower than the mark achieved in the statement score. In addition, none of the respondents (n=0) or 0 % scored themselves 10 points on the VAS for cultural practice.

In challenging racism, the findings in this section also revealed some divergence and contradictions. Although 100% (n=24) of respondents agreed with statement D1, *“Subtle forms of racism are as damaging as overt forms”*, and 75% (n=18) of respondents agreed with statement D8, *“Stereotypes have an impact on how clients are treated”*, just 42% or (n=10) gave a VAS self rated score of between 8 and 9 points for the statement D12, *“I am very confident to challenge racism and discrimination towards clients, carers and staff (Higher)”* and no respondent allocated themselves the maximum 10 points.

It is clear there are inconsistencies and a degree of incongruity in the findings of this section. Respondents perceived themselves as having lower levels of cultural practice compared to the objective higher levels achieved in the statement scores.

Consequently, it is difficult to interpret the complexities of these responses. However, in interpreting these findings of high individual scores for culturally competent practice, it is important to note that, when combined with the individual scores from each of the other domains, **no** participant was allocated an overall level of '*cultural competence*'.

Given the information elicited from the previous three sections of the CCAT, it is not surprising that the practice scores highlight some discrepancies, albeit not entirely informed by high levels of cultural knowledge or cultural sensitivity. Similar to other domains, respondents may have been careful to tick the 'right' boxes and engage a positive bias. Indeed an element of chance may also have returned the high scores in this section.

Nevertheless, of particular interest in this CCAT finding is a lack of confidence to challenge racism or discrimination by a significant number of respondents as demonstrated by the VAS score and yet this appears to contradict the objective statement scores in this section. Why is this so? Is it an apparent reluctance by nurses to name and address racism and discrimination in their own practice amongst colleagues or throughout the nursing service in Liffeside?

It may be that nurses feel that they lack the skills and knowledge of how to challenge racism and discrimination within a professional context. It may also be that they are not interested or motivated. Furthermore, the inconsistencies and apparent contradictions in the cultural practice findings raise further questions. Perhaps the environment that the nurses are working in, including the health care organisational system, is disempowering and therefore it is easier for them not to challenge racism?

Another consideration in attempting to analyse this part of the study is whether it is fair to expect nurses to be culturally competent in a short space of time. This however, is only speculation.

Other variables such as individual personal attitudes and behaviours and socio-political influences, including local organisational factors such as support and resources, must also be considered.

As intended and stated for the purposes of this study, the CCAT was a valuable tool in gathering exploratory baseline data. According to the formula used by the CCAT software analysis, the overall findings revealed that all of the 24 participants had been allocated a level of cultural awareness.

Although this finding can only be interpreted in terms of the principles of the CCAT; nonetheless, they do help to give an indication of the stages of cultural competence development occurring amongst the nurses. What is important here is consideration of the context specificity, client group specificity and the culture generic and culture specific competencies in the local area. Given that a large number of nurses in Liffeside are practicing only at the level of 'culturally aware', the interpretation of these findings gives rise to a number of possibilities with regard to developing cultural competence in the service. Consequently, this is an important finding as a baseline assessment and is useful in terms of planning and guiding future service development.

Although none of the participants in this study have revealed themselves to be culturally competent in accordance with the CCAT, it is not unreasonable for them to think they are culturally competent. This finding is perhaps unsurprising as there is evidence that nurses, up to this point, were unaware of the concept of cultural competence and the discipline of transcultural nursing. They had no opportunities to specifically question and consider their practice in a reflective professional way until participating in this study. The CCATs mostly demonstrate that nurses may perhaps have wished to be seen as competent and caring; however, there is evidence of gaps between their learning and their actual practice.

In many ways it is good that they are culturally aware as this may make subsequent steps in the process easier to achieve. Although the CCAT findings demonstrate that the nurses' appropriateness may not be polished enough, by keeping with the CCAT and PPT model, nurses should move to the next stages of cultural safety and eventually cultural competence.

On reflection, it would have been helpful had the scope of this study allowed the re-use of the CCAT to further expand on data findings. If undertaking future research

related to this topic in the same location, I would recommend the complete utilisation of the CCAT as endorsed by the authors. This is where pre- and post-professional facilitation and education, including further follow-up and evaluation, over a lengthier period occurs and would most likely generate deeper analysis and further meaning. Through discussion, exploration and observation of a facilitated programme over time, nurses could perhaps reveal other 'hearts and minds' factors that influence attitudes, behaviours and practice when working with culturally diverse clients.

On further reflection I found some limitations of the CCAT, relating to the terminology and language used in the questionnaire. For participants unfamiliar with the discipline of transcultural nursing the opportunity to use a glossary of terms may have been helpful. In some cases the terminology required explanation by me as the researcher and the inclusion of a glossary with the survey may have been helpful. However, in hindsight, given the period of time and the unprecedented level of change that occurred in the area, it would not have been unreasonable to have expected a greater awareness of terminology and confidence in its use.

Although some interesting and useful data was revealed by the CCAT assessments, the qualitative findings are much more revealing. The use of individual semi-structured interviews allowed an opportunity to modify the line of enquiry and to gain more understanding and interpretation of the experiences of community nursing staff in the area. Using a qualitative approach, the following section will attempt to expand on and further explore the transcultural experiences of nurses in the Liffeside area.

Qualitative Data Findings

A large volume of original, rich and descriptive data was generated from the semi-structured interviews. It contained a wide variation from the work-based experiences of the community nurses in Liffeside. Using the editing interpretative approach described earlier, the findings provide a fair representation of the experiences of respondents. Five key themes, including sub-themes, emerged from the analysis of the interview transcripts. It is beyond the scope of this report to present all of the data generated from the enquiry. Table 2 (above) contains a list of the five key themes and

corresponding sub-themes to emerge from the analysis of the original data. The following sections will outline these themes in more detail.

Theme One: Experiencing change in local population

The nurses offered insights into their experiences and particular attention was given to the rapid nature of the change in local population. To a lesser degree community nurses also considered other underlying factors affecting this ‘new’ population including migration, global health issues and barriers to access that affected people’s health and wellbeing. Some outlined how this impacted on their nursing responses.

Rapid nature of demographic change

All participants acknowledged the rapid change in the demographic profile in the Liffeside health service area. In the main, their work based experiences reflected the official population census findings for the area. Nurses working fulltime over six to ten years in the locality commented on the speed of change they experienced and how they were responding to an increasingly ‘different’ population that they perceived to be growing at an unprecedented rate.

Nurses described the extent of this impact as significant, using words such as “*massive change*”, “*major difference*” or a “*big big change*”. All of the interviewees stated that they each now had a caseload of families from different cultural backgrounds and ethnic minority groups and that this was not the case ten years ago.

“...when I started the estates were just starting to grow...lots of families of all sorts of nationalities were living in those houses at that stage....” (P7)

Nurses who had come from other areas had observed the change in population in the Liffeside health service area and attempted to understand how the services could meet the needs of the different population.

“.... I can see a huge difference here in Liffeside health service area since I moved....I know each area is different...this is unique...as far as I can see it isn’t quite developed yet here for this multicultural population...in the same way that my previous area was well resourced for say...care of the elderly...maybe it’s because it seems to have happened all of a sudden.” (P2)

For some nurses, working with an ethnically diverse population was a first time experience, even though they had worked in community nursing in the area for a number of years.

“I definitely notice compared to my previous area there’s a lot more foreign nationals living here now.....like I’d never actually had anybody from a different country on my case load before here....” (P10)

The changing profile of the population brought many opportunities and challenges for health care staff in attempting to address and meet needs appropriately. Nurses who had practiced exclusively in the Liffeside health service area described this impact and how it evolved over time particularly in relation to working with immigrant families:

“ I can remember in the earlier days when I was here on my own...before other staff came here.....in two of the estates where I work....I received something between thirty and forty birth notifications in one month alone.....sure that was just unheard of...and the majority of these were non-National families...”(P7)

From their experiences, nurses described their observations of the migration process and settlement of families. Interestingly, for some nurses, the experience of providing care throughout the life-cycle was relayed with an element of surprise and seemed unexpected.

“...in the six years there has definitely been a big big change...families are now established...families that wanted to stay are staying and having their second and third child.... I’m meeting the newborns that I examined back then in the local primary schools now when I do visits...” (P5)

Nurses also referred in a lesser extent to other experiences with migrant families in the area over time that demonstrated how relevant the continuum of care was to these new immigrant communities. For example, they spoke of assisting and supporting those with aging parents or terminally ill relatives who had arrived to live with family.

“....I have noticed a trend lately where some immigrant families...you know the grand parents may come back and they try to care for them here in their homes...I’ve noticed a few issues like that.”(P9)

However, nurses in this study appeared to describe their experiences of working with elderly immigrants with a different understanding or interpretation.

“...well you know normally as a PHN you’ve gotten to know them over the years...like daughters, mothers, grannies even great grannies in some areas all living close to each other...but with some of the non-nationals you can find yourself dealing with older people you’ve never met before...like all of a sudden...I find that strange...” (P5)

The excerpts above illustrate how nurses understood situations with immigrant families within the normalised context of working with the indigenous settled population. The unexpected presence of an elderly person who had not been ordinarily present in an immigrant’s home required some re-thinking and reflection and a challenging of assumptions by some nurses.

“...if you asked me six or eight years ago...it was a different story....I suppose working here now I don’t feel it’s a big issue....so I’ve worked through it now...”(P4)

Reflecting back, nurses felt they were now working with an established demographic and things were more familiar in comparison with the uncertainty of the earlier days. Interestingly, the assumption by nurses that families were only staying in the area for a short time or that immigration and / or cultural diversity was a temporary matter began to fade as time moved on. Perhaps this can be viewed as a consequence of further interventions with some of the same families at later dates.

Over time and with experience, nurses became more aware of differences and how to respond. More often than not, knowledge and skills evolved from experiential and informal learning. Some of the nurses acknowledged the perceived benefits they experienced from working over a period of time with families who remained in the area.

“...I’ve moved about in Liffeside health service area a good bit...and now the people I meet tend to be in the country a few years....it makes it much easier....to work with...because they know the system and they work along with you or within the system...”(P4)

However, it is the appropriateness and significance of these responses that warrants further analysis. The above experiences could be interpreted as nurses tolerating cultural difference with an attendant expectation of assimilation rather than a motivation and openness to developing cultural competence. There is an expectation at times from nurses that the change must occur on the part of the service user and not from themselves as nurses.

Local health needs linked to global issues

Nurses considered global development issues such as poverty, war/conflict and migration in the context of working with some ethnic minority service users and immigrants. In their encounters with immigrant families and ethnic minority groups, nurses demonstrated an awareness of underlying social, economic, and environmental factors that can affect people's health and wellbeing.

"....because we don't know what terrible situations they may have come from...you're not quite sure what you're dealing with....some may have come from very stressful situations...where they have no influence or control over their situation or how they even got here." (P2)

Although such awareness is significant for the development of cultural competence, these types of responses may also have been influenced by other factors such as media coverage. Very often sensationalistic reporting on the Irish immigration experience contained an over emphasis on the number of refugee applications and asylum seekers entering the country.

"Yeah...Liffeside is very mixed now – you see a lot more Black people and asylum seekers living here now...it's very noticeable..."(P2)

Consequently, there is a possibility that nurses may have unintentionally considered immigrants as refugees or asylum seekers or seen immigrants as a disempowered and disenfranchised population. This may have resulted in inadvertent stereotyping of some groups of people. For example, in most cases the term 'asylum seekers' was used as a catch-all phrase to describe Black people or people from ethnic minorities in the area. Nurses appeared to be ambiguous and unfamiliar with the accepted terminology and how to formally differentiate the terms and use them appropriately. Interestingly, there was little evidence of nurses assigning or referring to peoples' identity by the official limited categories, such as Black Irish or Asian Irish.

However, a minority of nurses in the study were clear in conveying an understanding of the heterogeneity and complexity of the ethnic minority demographics; by acknowledging different social circumstances and recognising that not all Africans were refugees or asylum seekers.

" ..not all of them are asylum seekers....maybe a lot of African nationalities don't necessarily come from poverty....and are affluent and come from very

well educated backgrounds....and then here they are considered refugees...and that's hard on them..."(P3)

These insights appear to have occurred following time spent working with service users, although the language used could be interpreted as continuing to portray a possibility of 'othering'. On further probing and exploration, terms continued to be used interchangeably.

"...a lot of them in my experience are very healthy.....they are younger and of an age where they have travelled to set up new lives...starting families and looking for work...I don't tend to see too much general or chronic ill health ..."(P9)

Interestingly, some nurses characterised their contacts with increasing ethnic and cultural diversity by focusing on their clinical case load, particularly on communicable disease and the prevention of the spread of infection.

"In my experience more and more of our interventions with multicultural clients or families is for typical public health issues like DOTS or public health notifications... ..all these can be very sensitive..."(P7).

"You do wonder a little about infection control and all the travelling...you know...different diseases and stuff.....I'd be concerned about that...especially with the children and vaccinations..." (P5)

Although this is an important element of public health nursing, it may suggest that nurse's understandings of transcultural nursing and migrant health approaches were narrowly defined or interpreted within the context of their own ethnocentrism and learned bio-medical models. If so, this can lead to social exclusion and stigmatisation for people from ethnic minority communities and may evoke prejudice and discrimination among health workers and services.

In addition, some contrasting approaches were also evident. Nurses were also conscious of the importance of assisting migrants towards integration and tended to apply a wider, more social approach to the application of care and support.

"I remember back then you'd be at your wits-end trying to link them in somewhere you knew they would get support or something...even to learn English...coz you weren't sure what bad situations they were coming from..." (P8)

They keenly valued their contribution towards ensuring that some level of social integration occurred in the community care context, enabling health and wellbeing benefits.

“We as public health nurses do have a role in this type of thing....I notice this all the time....it’s the social determinants of health stuff....but we’re usually busy with the medical nursing and other things....it’s frustrating at times...” (P5)

Nurses clearly have an understanding of the social determinants of health. At times they appear to be conflicted and constrained in how to respond within a transcultural healthcare context. Their own acculturated ways of working within particular biomedical paradigms, including other structural and organisational constraints, may perhaps have impacted their practice. However, there is evidence of nurses understanding the politicized aspects to their role and the significance of encouraging ethnic minority service users to become more empowered.

“You know it’s all the long term things that make a difference in the end...I would say to them...go out and find out where community centres are and meet others and set up a group to meet and chat....you know maybe a group of African or Muslim mothers...I’ve tried to set these type of things up...” (P10)

Other nurses highlighted the need for a community development approach to public health, whereby new ethnic communities could address their own health needs in a social model that would encourage empowerment and support for themselves. Nurses portrayed an interest in working collaboratively in such circumstances.

“In public health nursing, sometimes there is too much emphasis on health and not enough on wellbeing....I think there is a need for more community centres where people can come and seek support but also support each other” (P5).

While nurses acknowledged that overseas experience ‘did not have all the answers’, they could understand the challenges and understand what it was like to be immigrants themselves and this helped in developing further understanding and empathy.

“Sure I know in some ways what it’s like to live and work away in another country, you know things seem strange....most people want to be home with their loved ones....lots of Irish nurses have always travelled overseas for work...I know some want to do it....but others were forced...and that’s not easy...but you learned a lot...” (P7)

Others shared and expressed their own personal experiences of global health issues that had helped them consider a broader perspective. This knowledge and experience was applied with purpose of being of dual benefit to service users and colleagues.

“When I came back from Saudi, human rights were a big thing for me....I even joined Amnesty [laughing]....my understanding about health was different...you’d have a lot more empathy for people and poverty and stuff....like people coming here now from countries where there is war...I would understand that now why they may have to leave their homes...that’s not easy” (P10)

The above transcript excerpts describe personal and professional experiences that can inform cultural competence development. This mostly occurs in the practical experiential environment. Although familiar with theoretical and practical knowledge of the social determinants of health, community nurses were unfamiliar with specific cultural competence approaches to assist them. Nonetheless, by acknowledging these factors and influences, nurses were demonstrating some level of commitment to developing their cultural competence. However to what stage would this evolve?

Theme Two: Racism

Interestingly, the subject of racism was not freely or explicitly introduced by any of the participants and was only named in response to probing questions asked directly by me from the interview topic guide. For example:

“What experiences of racism or racist incidents have you experienced (if any) in the course of your work with colleagues, within the service or amongst service users?
[Researcher]

Understandably there was a clear reluctance to acknowledge or name racism as an issue amongst colleagues or within community nursing locally. Responses were evasive and hesitant.

“am...am...[appears visibly uncomfortable and nervous in responding]....I’m trying to think now....[pause....sigh...]....I haven’t to be honest....some people make comments in general I suppose about different nationalities....like....‘they probably wont turn up’ or ‘they’re not good for attending’I haven’t heard anything worse than that...” (P1)

“Well I haven’t been here all that long so I can’t say, I have to be honest. Am...among colleagues or others here....am...no” (P10)

I observed a noticeable change during the interviews in the demeanour of nurses when the question of racism was raised. An increased level of unease and discomfort was evident from most and was evident in longer pauses, silence before responding to the question, or shifting uncomfortably on the chair. Facial and non-verbal expressions often suggested they were waiting for a sign of approval or prompting from me to instruct them on how to proceed.

Reluctance to name it as racism

I had anticipated that this was a sensitive issue and that people might have been apprehensive with a professional peer. Understandably they may also have wished to portray professional cohesiveness amongst themselves, the service and the organisation.

“I wouldn’t say from my colleagues as such now...you have to be a bit professional about that....whatever your feelings are” (P8)

“....certainly I don’t think I’ve experienced anything at work....but yeah certainly out there...” (P3)

“...but it wouldn’t have been nurses now...” (P5)

It must be acknowledged that respondents would have been aware of my role as CNS with asylum seekers. Some nurses may have associated me with awareness raising training on diversity issues that I had given within the HSE, perhaps viewing me as an ‘expert’ in the field. This may have influenced their responses, resulting in people being more cautious and providing more positive accounts than were strictly true. However, others spoke freely of their experiences. These tended to be nurses who had began work in the locality in recent years and were less familiar with my role. Notwithstanding these constraints, there was in general, a reluctance to acknowledge the existence of racism among nurses and within the nursing service. Nurses were inclined to refer to the general social context using terms like ‘out there’ ‘people’ ‘the public’ rather than identify and associate racism and discrimination within the health care environment and nursing.

“I think the reception area gets a lot more of those issues.”(P10)

“ I wouldn’t say so....now I would have heard a lot from people who would have had....am...am...you know experienced stuff themselves maybe on the buses or that...” (P5)

When acknowledging subtle forms of discrimination, nurses often used euphemisms to explain in generalised ways, with little or no explicit description of facts relating to race, ethnicity or culture. Consequently, nurses did not appear to associate subtle forms of discrimination and ethnocentrism as being damaging or racist. Nurses tended to use language that highlighted or focused on other issues, avoiding terms that could be seen as explicitly racist.

“No I can’t honestly say that there is anything that has ever shocked me...am....no...no... I just think that sometimes people... [pause] might have been.... [pause...silence] ...maybe a little more impatient with people because of language difficulties and other stuff like that you know.....” (P5)

By contrast, very few nurses expressed their own power to discriminate, either consciously or unconsciously, when working within a cross-cultural health context. It was as if racism existed ‘out there’ at a remove from them as people, professionals and the health service – where nurses are perceived to be neither victims nor perpetrators of racism.

Many of the descriptions by nurses tended to reveal a lack of understanding of the construction of racism and ethnocentrism and a concurrent lack of awareness of their unconscious participation in ethnocentric attitudes, behaviours and actions. Indeed, some of the descriptions pointed towards an accepting or excusatory understanding of racist-type behaviour that could perhaps result in nurses being disempowered to respond.

“ Ah sure very often I guess it’s just like us as Irish....sure we’re always late...it’s just the way we are and they are...or in England we were seen as lazy...but we were just more laid back...[laughing]” (P6)

Challenging and Responding to Racism

All ten of the nurses interviewed stated that they would respond to racist remarks or incidents. However, this was somewhat incongruous as in the first instance, nurses were reluctant to name and acknowledge the existence of racism. Therefore, responses to challenging racism in the work place were mixed and ranged from some

being unaware of what to do, others choosing to ignore it and a (very) few stating explicit examples or confidence on the subject. Nurses continued to explain their proposed challenges and responses to racism in ways that were vague and evasive.

“Well of course you’d feel uncomfortable...but I can’t say that I’ve witnessed anybody being discriminated against...” (P2)

“I suppose we would need to speak about it...” (P1)

Other nurses attempted to personalise and employ empathy in their proposed responses to challenging racism and interestingly these responses tended to come from nurses who had worked abroad themselves and had experiences of immigration.

“I would have to say now I would probably challenge people....I would remind them that we immigrated ourselves...” (P8)

“I’d say to them you know....I don’t think you’re doing without from this service just because immigrants are here...” (P5)

A minority stated they would directly challenge racism and report more serious racist concerns to management and the authorities if necessary. However, it was unclear what they meant by serious racist concerns. As a consequence of the ambiguity and reluctance portrayed by nurses, it is difficult to ascertain what levels of racism nurses regarded as serious. Only three nurses interviewed explicitly named and acknowledged the existence of direct racism in their experience. One nurse outlined an explicit racist encounter she had with a colleague:

“Well, when I applied for something for somebody...the answer I got back was... ‘all those black women are having way too many babies and they shouldn’t be having them if they can’t look after them’...[uncomfortable laugh and pause] ...now that was terrible...because all us Irish women had way too many babies one time, huge families of 11 or 15 and that was the way of the world in Ireland at that stage...well I thought that was terrible and I fed this back to her....and also that it was a woman’s right to have as many children as she wanted...and she’s still allowed to have a service from us..” (P4)

In the above excerpt, the nurse clearly outlines her immediate response at the time with her colleague and demonstrates some degree of direct challenge to the racist incident. However, while the nurse is upset and clearly feels this response is racist and unacceptable, she stated that she did not follow any official line of reporting on this incident to management, explaining that she felt she had dealt with it satisfactorily.

“Obviously I did not take any official step or do anything official...I guess I was really taken aback by it....am... I don't know why I didn't make a follow-up on it...I just let it off and go....I had said what I had said to her and that was it...” (P4)

Local, professional or personal relationship issues might have influenced how a nurse chose to address such an issue. The response may be the result of feeling unprepared or lacking in knowledge of procedures, either locally or within the organisation. It is also possible that the effort of a formal procedure might be seen as more trouble than it was worth.

One example by an interviewee discussing racism within a clients' own home highlighted a number of professional and ethical issues.

“....if it happened in somebody's house and they're passing remarks [racist] like that, well I'm not going to tell them they're wrong in their own home...because its their home...I'm technically invited into it... you know it's not my place to say it then...unless like it was going to affect their care...” (P9)

Although this highlights a lack of will to challenge uncomfortable matters, it also suggests limited knowledge of the construction and effects of racism and a lack of awareness of how racism concerns professional ethical codes of practice. This contrasts with others who demonstrated limited awareness and insight into the possible affects of racism on service users and its impact on their wellbeing. A minority of the nurses who had lengthier experiences of working specifically with Travellers demonstrated a clearer understanding of the importance of challenging racism if encountered with colleagues or others.

“Yeah I would challenge people.....I find myself correcting them if they're using derogatory terms....like tinker or knacker...and tell them that they should say Traveller...or travelling community... (P6)

These nurses, who were now also working with new migrants, were more understanding of the effects of racism and discrimination on people and their wellbeing. They were more confident to challenge and address it having gained experience. Although these nurses had undertaken post-graduate studies with a considerable sociological input, in addition to their public health training, they primarily focused on experiential learning. Over time, they had learned by reflecting on the experiences of the people they worked with;

“Well it’s through respect really....and my understanding and what I’ve gained and gleaned from the Traveller people....by understanding their culture and the affects of discrimination and racism....I see it and experience it every time I visit a family in a halting site...maybe places that have no running water, toilets, or even electricity...I think this is discrimination....and people suffer because of it....” (P6)

In the main, nurses in this study tended to view racism or discrimination as an issue that they were uncomfortable addressing and were somewhat unprepared and lacking in confidence to explore.

“One man told me about his wife...who stopped collecting the children from school because she was called names one time....this is sad...as the same woman needs to get out and about....maybe people are racist towards them....but you can’t do much about it really...” (P9)

However, there is some evidence that, as nurses continue to work with ethnic minority service users, some reflection on the effects of social issues such as racism on health and wellbeing may be emerging for nurses locally.

“Well...I visited a family from Sudan last week...yeah...and he kind of said they don’t leave the house or go out really....but I didn’t really go into it much....so I don’t know if he meant because of racism...yeah...may be it was I never really thought of it like that....”(P3)

The above description demonstrates that some nurses appeared to lack confidence and had a limited view and understanding of the broader social implications racism can have within an individual and community health context. It may be that nurses are reluctant to challenge racism as they perceive and understand it as an overt or blatant experience and do not consider the different types that can exist. This disconnectedness and limited awareness by some nurses could have implications for the delivery of healthcare and may unintentionally serve to further alienate people who already feel socially excluded as service users. The impact of racism on health and wellbeing is a public health matter and requires further exploration and understanding by health care professionals in Liffeside health service area.

Discrimination

Interestingly, nurses acknowledged situations where they observed inequitable and discriminatory service provision to some ethnic minority service users. However, these incidences were described in detached terms where nurses mostly referred to

structural and service type barriers rather than to any individual interpersonal situations. For example, they referred to the lack of access to professional health care interpreters and the lack of appropriate translated health promotion and education materials. These issues, for them, highlighted an inequality in the service.

“In all honesty how can we call ourselves a universal nursing service if we can’t provide the same information or advice to all our clients...it’s not equal at times...its just not...we all know there’s people and families missing out on care and advice that could be more appropriate and improved upon...”(P5).

While acknowledging the existence of indirect discrimination some of the nurses felt personally and professionally compromised. They felt they had little means of changing the situation within the organisational system. Some descriptions reveal a sense of disempowerment felt by nurses in addressing these situations. These may be interpreted as being due to lack of knowledge or confidence or indeed a lack of motivation.

“It’s not fair on some clients....how can we provide an equitable service or care for people if they don’t understand us...it must be so frustrating for people...it is for me at times but we get used to it...[laughing]. I guess in some ways it is a form of discrimination...I can understand the reasons...but it’s not good for anyone....” (P9)

“..But there is very little resources available to us...and it’s hard to change the system...” (P5)

However, while all the nurses outlined difficulties with interpreters and other resources for transcultural care, not all associated this or named it explicitly as indirect discrimination. Others, in some health centres, were making efforts to improve the situation, particularly in the context of communication efforts. This will be outlined later. The data demonstrates uncertainty and ambiguity in the nurses’ understanding of the concept of racism as a form of discrimination. Nurses were mostly reluctant to name and acknowledge racism. Where nurses did describe experiences, inadvertent and unintentional racism in service provision was evident. Participants’ experiences of discrimination, direct or indirect, were mostly viewed as structural organisational barriers detached from their individual inter-personal relationships with service users and worryingly nurses revealed they had little power to change these circumstances.

On reflection, further probing by me may have been beneficial and revealed further findings and explanation. However, it was also clear that nurses were uncomfortable with discussing the topic. I found my own feelings and responses during the interviews at these points uncomfortable at times. Perhaps this was because I could empathise and relate to the experiences of the nurses – prior to my current role, I too was inexperienced and unfamiliar with issues of equality and diversity in the professional context. In the past I was unaware of how to deal with such issues and lacked confidence and knowledge, including the appropriate vocabulary, about how to address such issues.

However, as the interviews proceeded, I became more aware of my own limitations and strengths in addressing this topic with interviewees. I found it helpful to inform myself, from the literature, about the theoretical explanations about racism in nursing. In addition, discussing these aspects with my advisor and work colleagues and drawing from the learning of my own advocacy work with asylum seekers and refugees, proved empowering and helpful in proceeding with this topic in the interviews.

Theme Three: Focus on Difference

Using the ‘right’ Terminology : ‘They and Them’

During the interviews nurses expressed apprehension and indeed uncertainty about what terms they should use when referring to service users from ethnic or culturally diverse backgrounds. The majority of nurses used different terms when speaking about ethnic minority clients. Terms such as ‘*non-nationals*’, ‘*foreign nationals*’, ‘*immigrants*’, ‘*asylum seekers*’, ‘*refugees*’, ‘*migrants*’ ‘*ethnic minority*’ were used interchangeably. In some instances during the interviews, clarity and approval was sought by nurses directly from me when they began to describe their experiences. For example:

‘We have a huge amount ofam...am....[whisper]....what do I call them?’
(P8)

“I’m trying to think of the right words to say....” (P7)

While a certain amount of ambiguity exists among nurses regarding the most appropriate language and terminology to use, there is also evidence of some reflection by nurses as they encounter greater diversity in the locality. The following outlines this case in point.

“...when people say ethnic minority....I don’t know if it’s a great word to say or not...I don’t know what you should say really....now I think they mostly would prefer to be known as New Irish...would they?maybe that’s what we should be calling them...not an ethnic minority....but also they want to keep their own culture....they have a lot of values in their own culture....you’re only going to alienate them more if you do that...maybe say... am....Middle Eastern background or African.... yeah just say the term....say what they are.....I don’t know...” (P2)

Such an honest response may also be interpreted as a demonstrable willingness and commitment to grapple with and respond to the social changes locally. Although in the minority these understandings demonstrate a degree of reflexivity on the importance of terminology. However, there is also a sense of frustration and a lack of confidence. I was curious to know if it was participating in this study that enabled or prompted nurses to reflect or whether it was happening for them in their daily work as a matter of course.

In the main, when describing their experiences, nurses used language and terms that demonstrated an emphasis on difference. The use of the words ‘they’ and ‘them’ was particularly noticeable as a descriptor, serving to add further emphasis on setting themselves (as nurses) apart.

“Oh Yeah...some of them are very different...have different ways about them....but that’s just their culture.”(P5)

“Well....as a starting point.....I have to accept you know that people are going to be different...” (P8)

Nurses tended to use this type of language when referring to service users and people’s ways of living and to ascribe commonly used terms from social public discourse and media without verification of facts. Although this language tended to be used inadvertently, it can nonetheless impact negatively on practice. Combined with ambiguity, ignorance of terminology and an over emphasis on difference, health care staff engaged in a type of ‘othering’ of service users and clients and were almost

unaware of how these types of attitudes and descriptions can bring about social exclusion.

“We would have learned a lot from them you know....they have good aspects...and bring some good...” (P3)

Interestingly, even nurses with experience of working with multicultural communities and who had expressed their concerns about exclusion tended to use this same type of language. Again, this demonstrates how nurses can become socialised into ways of working that become established as normalised patterns of thinking, attitudes and behaviours.

“I find them very polite and no bother...even though sometimes they take up an awful lot more of your time....” (P8)

The unconscious use of this type of language amongst health professionals can unduly influence staff attitudes and behaviours and further compound negative stereotypes and prejudices. Perhaps unintentionally, this understanding may also contribute and promote approaches immersed in tolerance and assimilation rather than more democratic intercultural and collaborative understandings. For example, nurses described some experiences as follows:

“Because they’re a very transient group you knew you were in for a rough period....they moved house a lot....you couldn’t find them....and that was a huge difficulty” (P5)

“You’d be amazed as you get to know them....they have very close networks within their areas....a lot of them a lot of times seem to be in clusters...” (P5)

While these responses may be the result of stereotyping and unwitting racism, they indicate a limited knowledge and understanding of some of the needs and realities of people from migrant groups. The use of stereotyping demonstrates the possible consequences of working from a ‘one-size-fits-all’ model of transcultural health care and requires reflection by health care workers.

For example, it is a reality that for some, moving accommodation and / or choosing to live in areas where others from their own background live, helps them to feel supported and secure.

Conversely, despite the focus on difference, some of the interviewees believed that treating everybody the same was the answer.

“Sure I just try to treat everyone equally...you know...the same... I don’t think you can treat them any different to anyone else or any other family...that wouldn’t be fair...” (P3)

“Well....I suppose like I would with all families...I don’t treat them any differently...I see what concerns they have...try to deal with them and get things sorted as best I can...so it doesn’t really affect any way I deliver care...at least I don’t think it does”!(P9)

By treating people the same, the nurses were not intentionally disregarding cultural factors but thought they were offering equitable services and care to all. However, this approach demonstrates some misunderstandings or limited knowledge and reflection on the principles of equality and of what the provision of equitable service truly means. This will be outlined and considered further in the discussion section.

Working with ‘different’ cultures

There was a mixed and sometimes contradictory understanding of working with people from different cultures. The majority of the nurses demonstrated narrow and fixed understandings of culture. The essentialising of the concept of culture was evident at times. Working around culture, rather than accepting and working with it as a fluid concept, was seen as a way of being able to carry out their nursing roles and duties.

“I guess you should just try to understand them...and work around it...like they pierce their babies ears...if they want to do it they’re going to do it...that’s just what they do...its their culture” (P1)

Nurses tended to view culture as a fixed entity with little or no scope for change. Nurses spoke of culturally competent care in terms of cultural imposition rather than an emergent behavioural process, derived from social interactions with the new host community.

“ It can be very difficult because they have their own value systems and beliefs where they come from....so you kind of engrain a bit of your own values and that kind of thing on them....I suppose we tried to mould them into our way....trying to change them I suppose...”(P4)

“I would appreciate their differences and respect their differences....like I would relate to them on that level.... I think now that they are here and they have settled and fitted in ...it’s easier...yeah...a bit easier to do our job...coz they understand it better.” (P2)

Such understandings (whether conscious or unconscious) possibly stem from unwitting ethnocentrism and ignorance about cultural competence and could continue to compound assimilation and tolerant approaches to care. If nurses are expecting clients to ‘fit-in’ to the system, they do not demonstrate a clear motivation or willingness to consider change or other ways of working, that may be more appropriate to the needs of diverse clients.

For some nurses, encounters with service users whose values and beliefs were culturally different from their own, reinforced generalised and sometimes stereotypical attitudes and reductionist assumptions.

“...sure all the African mothers want their new born boys circumcised....that’s just their thing...you know....it’s just their culture...even though we don’t do it in Ireland....sure they’re going to do it anyway...[referring to circumcision]...I don’t bother explaining anymore....their belief in it is so strong...” (P8)

Focusing on difference in the context of cultural and ethnic diversity demonstrates an over simplistic understanding of culture. At times, nurses failed to consider complex social influences on health or the meaning of health and cultural ways of living.

“...If I could ban that African infant formula...what’s it called...Cerelac in the big tins...I would...they all give it to their babies...and it’s not good...not the most nutritious....in fact the babies are big bruisers...far too big...” (P5)

The above excerpts suggest nurses did not engage in negotiation with service users, neither understanding the culture nor exploring whether any change was possible. These approaches can be seen as ethnocentric, stemming from western bio-medical understandings of health care and could result unwittingly in cultural conflict.

The above views can be contrasted with some other nurses’ descriptions of their experiences and practices, notably those who reflected on how they (nurses) understood and interacted with ethnic minority service users and learned from ‘them’. Nurses who worked with Travellers or had previous experience with diverse communities had greater awareness and understanding of communal, social and

cultural influences on health and wellbeing. However, this was not exclusive to those nurses.

“Sure when you arrive in a halting site to see one mother or a family as planned...you might end up seeing four or five mothers and lot’s of kids....sure that’s just the way it is...I know that now [laughing]...life for Travellers...is about sharing even health problems, cures and supporting each other” (P8)

“Well...I’m probably more aware of where people are coming from.....I’m not as quick to jump to a conclusion or make a judgement about a person just because they’re from another place or live their lives a certain way....” (P6)

Other nurses continued to demonstrate and explain well intentioned individualised nursing care approaches. In themselves, these are valuable and important at times; however, they can have limited value in some transcultural contexts. In addition, there was a tendency by nurses to believe that individualised approaches to care would eliminate any inequalities.

“...you know there’s no great difference really [caring for people from other cultures]....you should really just apply an individual care plan to their needs...sure that’s what we do with everyone...like that’s nursing care” (P3)

Nurses who mentioned this approach did not seem to be aware that some cultures place higher degrees of value on independence and individuality, while others may value interdependence and shared collective world-views and responsibilities.

Most of the findings to date have primarily focused on difference rather than on commonalities or similarities. In considering their work with different cultures, a minority of nurses reflected on the value of focusing on what people have in common and the importance of connecting with people based on shared experiences of culture and cultural ways of living.

“Sometimes you just realise that human nature is the same in all cultures...for all of us....we all laugh and cry.....and have basic needs....and respond to these the same.....ok we might eat different food and express ourselves differently and stuff but I keep it in my mind that people need people...” (P5)

These views differ from the notion of treating people all the same, with the ‘one size fits all model’ of nursing care. The experiences portrayed by the nurses demonstrate the potential of reflection, which can lead to a connectedness that can enhance care. Reflecting on their interactions with people led them to consider the importance of effective communication and aspects of relationship building. The findings in the

following section will explore nurses' experiences of building relationships and the challenges of cross cultural communication within the community nursing context.

Theme Four: Building Relationship and Communication

Connecting with people

In the main, nurses acknowledged the importance of relationship building and connecting with patients and families and considered the wider communication context of their involvement in offering care and support.

"...you know you don't just go into a house to see a baby or patient...you go into a family.... into peoples lives....so yeah you do want to and need to get to know them and where they've come from....not in a curious way..." (P3)

"...regardless of where people are from...from what you see in front of you there is a lot more behind the person..." (P4)

Even though human, structural and organisational barriers to communication existed at times, there was evidence that nurses continued to place emphasis on engaging interpersonally with clients in order to develop a therapeutic relationship.

"I think if you know somebody has come from a very difficult time in their lives...you sense they may be depressed or isolated.....you have to say to yourself...I understand where that's coming from...it will take time and trust...and it's not all about language and being able to communicate at that level....if you don't do that I'm not sure you're doing your job right..." (P3)

Nurses continued to see communication and language as key elements in building relationships and not just exclusively in the context of non-English speaking service users. Nurses who had experience of working with the Traveller community and other marginalised people, acknowledged the significance of using effective and appropriate communication, even when the nurse and client shared a common language. This was also mentioned in the context of adult literacy and delivering health promotion messages and information.

"You have to chose your words very carefully and not use any kind of big language or big medical terms.....they will hang on every word you say..." (P6)

“To be honest, at times even the English speakers ...especially the Africans I can find hard to understand...but then again I have some Irish that can’t read or write...so you try to stay alert to that kind of thing....it is fairly common around here...” (P7)

Interpersonal skills and shared values like empathy, respect and trust were mentioned and demonstrated by the nurses when working with clients, regardless of cultural or linguistic differences. Nurses identified these factors as essential prerequisites for developing positive relationships and healthcare outcomes with people. Interestingly, although nurses had received no specific training in intercultural communication, the above excerpts demonstrate an understanding by nurses of the importance of the technical elements of communication (verbal, non-verbal, paralinguistic etc.) in the transcultural healthcare context. It demonstrates intuitiveness on the part of the nurses in attempting to understand and connect with patients, despite language and communication difficulties.

Understanding communication within a cultural competence context can benefit all in society, not just people of different cultural linguistic backgrounds. Unless nurses and health care professionals remain sensitive and aware of this, there is a risk of further alienation and exclusion for vulnerable people.

Interestingly, the nurses interviewed expressed a clear confidence with their overall general communication abilities but they tended to be modest and to play down the value of their knowledge, skills and experience.

“...it’s just what we do.....after all...people are in their own homes...they’re probably comfortable there anyhow compared to being in a clinic....but it’s good to be non-threatening and make people feel comfortable...a smile and being respectful goes a long way...it might seem obvious but it’s just common sense...”

These descriptions portray nurses as proficient communicators within the health care environment; however, this predominantly occurs within a shared language and inter-professional communication context (English speaking and bio-medical language and terminology, with access to resources).

The interview data also revealed contradictory and inconsistent experiences of relationship building and communication between nurses and culturally diverse clients. It is clear that at times nurses found communication difficulties an

impediment to developing relationships with non-English speaking service users. Not sharing a common language interfered with the development of effective nurse-client relationships and was for some a source of frustration. The following excerpt by a nurse outlines such an experience in a simple but clear way.

“...I don’t know how to explain or describe this...or what’s the word...probably clicking...it’s just yeah...you don’t click...you know there’s a barrier between you and the client...You don’t end up building a relationship...you just end up asking small questions like...where are you from?”(P10)

In the primary care environment, communication can become more challenging for staff and service users. Absence or lack of a shared common language between care giver and client can be a real barrier. In public health nursing this is further exacerbated by a lone, home based working environment with no immediate access to interpreter or colleague.

“I think language is a huge huge problem....and you know, as much as you try to get to know their culture you don’t really because at times you can’t communicate....”(P3)

Most of the nurses acknowledged and outlined the challenges and frustrations they experienced in developing effective therapeutic relationships with people from different cultures and language backgrounds. Communicating with people who did not speak and understand English proved difficult for nurses attempting to build relationships and carry out their role.

“...well it certainly is a barrier because you never get onto a friendlier basis...or know exactly how they’re feeling or how they’re thinking...” (P9)

“When I came to Liffeside health service area initially, I found it extremely frustrating because I couldn’t communicate with my clients...there are some I still can’t communicate with in the same way I would let’s say with their Irish neighbour...” (P7)

When it came to communication there were mixed feelings expressed by nurses and an almost defeatist attitude at not being one hundred percent certain of the outcome of their interventions. This was shared equally with a concern that they were unable to offer an equal standard of service.

“you kind of take your time and use simple words, take it slowly but you never really fully know do they understand it totally....sometimes I feel a lot of the

intent is missed...but there's no way around it..... they may pick things up wrong or not be able to clarify with you....you do worry about it and it's frustrating at times" (P10)

The above descriptions portray a willingness and desire by nurses to connect with their clients – but only to a certain point. In the absence of basic resources for effective communication, practices can develop and may persist, that are unequal and discriminatory for some service users. More importantly, the persistence of such ways of working becomes the accepted norm, with limited will or knowledge to implement change.

'Getting-by' with communication

Nurses mentioned experiences of communicating that ranged from using broken English, gestures and hand signs, to using family members with limited English proficiency and typed computer assistance when required. It was evident that nurses needed to be practical and resourceful.

"In many ways it's been a knee-jerk reaction... thinking on our feet stuff and responding to people even if they don't speak English. That's hard going at times..." (P5)

Although expedient and developed of necessity, these practices are questionable in terms of appropriateness, quality of service and more importantly from the perspective of nurses' professional accountability. Of particular significance in Liffeside, are the minimal standards that most nurses appear prepared to maintain. In some instances it is demonstrated by a lack of reflection.

" I don't have any problem really with non-English speaking families...they don't ever mention any problems with communication they seem to understand...like we get by...you know using broken English and lots of hand signs [laughing] I'm sure they'd say something if there was a problem...but they seem to understand.." (P2)

Some nurses, in becoming more familiar with patients and families over time, established their own means of communication that they felt was sufficient. However, there appears to be an understanding and acceptance that regular contact without clear and effective communication was appropriate for building relationships and functioning professionally as a community nurse.

“Its amazing how you try to get by with sign language and gestures...often they mightn’t have the language but you’d know they get the message or at least some of it...” (P5)

“...but I wouldn’t consider it a huge barrier for what I’m going in to do...you generally get by” (P8).

It could be considered that in some instances nurses felt that by regular contact with clients this negated the need for interpreters and the frequency of visits may have given the impression of forming meaningful relationships. However, in the absence of effective means of communication this certainly calls into question the level of professional interventions possible and thus the quality of the nurse-client relationship during such visits.

Understandably, nurses appear to be content to fill the gap in a practical way, at a given moment, most often out of necessity. The above extracts, although describing a willingness and awareness by nurses to communicate with patients, also raise further questions and professional considerations, as nurses do not appear to be overly concerned or motivated to seek further support. Why is this so? Is it possible that nurses feel disempowered in the workplace or have a fear of being perceived as weak by management if they look for help? Indeed, it may simply be down to misunderstanding and lack of clarity in procedures and maintenance of professional accountability.

“Over the years I’ve learned to adapt and use common sense...unfortunately as health professionals, we don’t have access to translators [interpreters] and that’s a big burning issue...” (P7)

“I know it’s not ideal...but it fills a gap and saves me time and maybe the health board money and I suppose it is a practical help to me” (P10)

While well-intentioned, such approaches can result in prolonged, unreflective practices and inertia by nurses, resulting in very little development and change. A culture of being content to ‘just get-by’ can emerge.

“Well....most of the people are here a while now and have enough English.....if they don’t, you just try to get by...I’ve learned to adapt and improvise....sometimes I use other family members...or friends.”(P7)

This attitude raises more fundamental questions as to how minority clients are viewed by healthcare staff. More worryingly, it may result in further barriers to access for

service users from different linguistic and cultural backgrounds, as they may avoid services which they are unable to fully engage with. If so, this may exacerbate existing health problems.

Findings here reveal there is increased room for error and risks in the application of healthcare if this approach to intercultural communication continues. Examples could include misinformation, nursing misdiagnosis or the risk of services or individuals being found guilty of engaging in discriminatory practice, whether direct or indirect, intentional or unintentional. In the main, nurses did not appear to explicitly highlight these factors as an issue or concern when outlining their experiences.

Nurses were practical and pragmatic in their understanding and awareness of when to use others to assist in the context of working with limited resources in homecare. In general, nurses were grateful for assistance in communication from others (family friends, neighbours).

“ Otherwise you’d never get any message across....it’s better than no interpreter [professional health care interpreter] at all...you have use your common sense at times...someone is better than no one..” (P9)

Of significance is the fact that none of the nurses who were using family or friends (adults) for interpretation referred to the possible negative effects (physical, emotional or psychological) of conveying sensitive information from or to a friend or family member. Similarly, reliance on others (apart from the patient) for communication can change the dynamic of power in the delivery and application of care to people; however, nurses did not mention this in their experiences.

Although some nurses seemed sensitive to the consequences of using children as interpreters in clients’ homes, the evidence suggests it did not appear to be ruled out completely. On further probing of this particular issue (children as interpreters), the majority of nurses were aware of the implications of using children and the ethical and professional dilemmas that can arise. Most nurses stated they felt it was not appropriate to use children as interpreters and avoided this practice if at all possible.

“...so you’re trying to deal with them by sign language and stuff...or using family and friends...of course I’d try to avoid using children.” (P8)

“I wouldn’t use a child for this or put a child in that position....you have to be professional and sensitive to the child’s needs.”(P5)

Some nurses did mention their experiences of communicating through older children and teenagers and stated that they felt compromised in this type of situation.

“I had to communicate through a mother’s teenage daughter once.....I felt it was the only option I had ...but at the back of my mind...you know you feel it’s not right...”(P4)

“ It’s not ideal having to communicate to a mother about her condition through her teenage son who has just come in from his PE class in school...it’s a bit awkward [laughing]” (P9)

These situations tended to be infrequent and arose in the context of nurses working with immigrant families that were in Ireland for longer periods of time. Nonetheless, these situations raise professional and ethical considerations for nurses in practical working environments. In addition, it also brings into question the level of professional preparation required by nurses in planning home visits and poses questions as to ‘Why do nurses find themselves in these situations’?

Use of Professional Interpreters

A number of mixed findings emerged from the interviews with regard to the use of formal or professional interpreters. Apart from ignorance about how to source interpreters, other issues such as barriers to accessing professional interpreters and a reluctance to use them were mentioned. This appeared to be incongruous with other aspects of nurses’ descriptions and experiences.

“I haven’t had to contact an agency for an interpreter...now I know they’re probably available if you look but I haven’t actually had to access one...there’s usually a family member...” (P10)

“...you just couldn’t get them [interpreters] or have them as much as you would have needed them...” (P5)

Even though nurses were keen to ensure effective communication with their patients, eight out of ten interviewees had never engaged the service of a professional interpreter in their nursing practice in Liffeside. This was evidenced by nurses who had worked for varying lengths of time in the area.

“...as for interpreters...well I’ve never used one.”(P3)

“I’m eight years here now and I’ve never worked with an interpreter [formal health care interpreter] ...I suppose I’ve never had the need to...” (P7)

Therefore, in exploring the use of professional healthcare interpreters, a number of contradictions began to emerge. For example, the majority of nurses had previously acknowledged the need for effective communication methods due to the challenges they faced in caring for and communicating with non-English speaking clients but they did not appear to seek out or utilise any formal interpreting service.

“You know I’ve never or heard of the girls [nurse colleagues] using such a service...I’m not sure one even exists for us to use here... I don’t think we can...I never really thought of it really...” (P5)

The evidence points to a hesitancy on the part of nurses to utilise and engage with professional interpreters. The experiences of these nurses suggest reasons ranging from a lack of knowledge on how to access the service, cost implications, discrepancies amongst other disciplines, and administrative and time delays. When asked to explain their experience, most nurses had the perception that such a facility was not explicitly available to them or their service. Nurses were aware that other healthcare professionals had access to and utilised interpreters; however, even though they recognised its value, they did not appear to insist on securing and using interpreters if they required it. It is also possible that this understanding had evolved based on assumptions built up over time by some nurses that such services did not exist or could not be accessed by them.

“Of course we would need them at times...but no....in general we don’t have access to interpreters [professional health care interpreters] ...unless in a very special case...then...am I’d have to apply or appeal....as far as I know GPs and social workers have access but in general we don’t have that right...”(P9)

However, there is also mention by nurses who had made efforts to seek the assistance of an interpreter. Some demonstrated innovative ways of availing of interpreters if they felt the need.

“If I felt I needed a proper interpreter... I’d get around it sometimes like I’d try to plan the visit to coincide with either a social worker or a GP ...where I know I could have access to their interpreter...” (P9).

“... I’ve learned over the years to go through the maze and the networks....it’s hard work...but you have to find ways...” (P7)

Although practical and useful, these responses could also be interpreted as lacking in confidence or 'know-how' and gives rise to questions about how nurses are motivated and / or empowered to seek such supports and make relevant decisions.

Among the nurses who had utilised formal interpreters in the course of their work, concerns were raised about the standard and professionalism of the interpreter. Issues such as confidentiality and the delivery of professional healthcare information such as medical terms seemed problematic. Nurses appeared apprehensive at the lack of formal preparation for working with interpreters and tended to lack confidence in this context.

“When I worked in the UK it was useful and it did help to have an interpreter with you but you felt responsible too...you know....things like consent forms and recording in your notes...it has to be done properly you need support and training..”(P7)

“Well you’re always a little unsure because sometimes the person interpreting may misinterpret or miss what you’re trying to say and get across....they may pick it up wrong or not clarify stuff with you...” (P10)

For some nurses, the conveying of information to patients using interpreters, whether formal or informal, was also a source of frustration and difficulty for them. This was explained as a barrier to building relationships but also a practical issue for planning care and imparting nursing advice.

“It’s very hard to build up a rapport with somebody when using an interpreter” (P1)

“If you want to build up a relationship with someone it’s a bit more difficult with an interpreter around and it takes up much more time....” (P7)

It is evident from the excerpts above that motivational and practical implications inform nurse’s decisions on engaging the services of an interpreter. For example, the hassle of finding one, having to seek permission from management, the probability that care would take longer and having to assume some formal responsibility in recording and documenting the intervention would appear to be factors that mitigate against using interpreters by nurses. However, nurses who had utilised formal

interpreting services outlined the benefits such as better planning of clinics, improved attendance and compliance and improved time management.

“You feel more confident you’re doing a more thorough job when you’ve a proper interpreter with you...of course it’s not easy and it takes longer, but you catch things you may not have if you didn’t have someone...you feel a bit better and so does the client...” (P7)

Apart from the benefit of clarity, one nurse described how she had learned about the social and political context of language and communication by using an interpreter and recounted how this impacted in her work during a home visit she had set up with an interpreter and client.

“ I remember it was a Kurdish man with chronic liver problems....he told me he spoke Kurdish so I found out how to book an interpreter and set it up.....but it didn’t go too well....it turned out they spoke two different dialects...[both were from Iraq]....they appeared civil and nice to each other...but it was awkward as the interpreter told me he didn’t understand everything...the patient was polite and grateful but said to me next time he would manage alone or get a family member...afterwards it was clear there were cultural differences between them...to be honest I was embarrassed but learned from it...”(P8)

The above excerpt reveals the learning that occurred for the nurse in terms of how language is constructed and used within everyday cultural contexts and the importance of how other values and meanings, not always associated with language, are represented and expressed. It demonstrates how verbal and non-verbal communication differs within cultures and how communication is derived from and influenced by many complex social and cultural factors.

Although having the best interests of their patient in mind, some nurses when working with clients in the presence of others found this to be intrusive and unnecessary.

“It really irritates me at times....when calling to some people...even though they speak and understand English...there’s usually someone else there with them....it’s like they insist on talking through somebody else...usually the husband....I always seem to be looking at him and talking to him....but it’s the wife that’s my patient”(P5)

This example reveals how the nurse failed to understand conventions around age and gender norms or collective (family) obligations that have significant cultural value and meaning to those who are ill. This may reflect an ethnocentric approach to

healthcare, informed by an individualistic Western philosophy, which focuses on the patient with limited attention given to the wider family and cultural context. It could also be interpreted as a stereotyping of men within particular cultures. Although the nurse finds it frustrating and difficult to understand, there is no evidence of moving beyond this thought process to reflect and consider the transcultural context.

Using Technology to communicate

Interestingly and perhaps unsurprisingly, most of the technological efforts at communication were instigated by client's families themselves when nurses called to their homes. This makes sense in the context that non-English speaking people living in an English speaking country may be more inclined to seek out resources to assist with their communication and improve their English. Another aspect is that technology enables them to maintain connections and communication with their families in their country of origin and this type of technology is likely to be used regularly.

Nurses described experiences of using some technological means of communication with both non-English speaking clients and people with low English proficiency. They included the use of mobile phones, lap-top computers and social media such as text messaging, Skype (camera and sound) and free translation packages such as Google Translate to assist in communication. Some nurses found this surprising but useful.

“There’s one older Pakistani woman I visit who has set up Skype with her niece who lives back home and she also has relatives outside Dublin over in the West... so she gives her niece notice of when I’m calling and when I arrive we can all chat together....it may not be ideal...but it’s very helpful I don’t even use Skype myself at home!”(P5)

Approaches such as these seemed to satisfy a need to engage with clients and get over the initial hurdle of difficult communication, while some nurses saw the value of utilising the information they gained to their own professional advantage.

“I’ve even started using Google translate for short notes, maybe to say I can’t visit or a new appointment...or general stuff...a simple print out to say I called please contact the clinic”(P8)

“It is amazing what you learn from working with different people...they can show you a lot” (P2)

Nurses did not mention any specific preparation or training undertaken by them in this regard. In addition, no reference was made to official or formal policies or protocols on intercultural communication in the local healthcare environment. It was unclear if nurses considered these types of technological methods of communication as appropriate to sustain in the long term or simply as another means to get by.

Theme Five: Professional Preparation and Support

In this study professional preparation refers to any type of formal and/or informal training or education in transcultural nursing or cultural competence offered to, or undertaken by, nurses in Liffeside. The experience of support refers mostly to informal supports established between the nurses themselves at local level, some of which involved nursing line managers.

Evidence of opportunities to meet and discuss transcultural issues and share information with each other were described. Structural supports or lack thereof experienced by nurses are mentioned to a minimal degree, such as local policies and procedures, resource issues, specific training, and guidance from nursing management. Experiences of wider HSE organisational supports are also mentioned to a much lesser degree.

The nurses acknowledge the rapid nature of the demographic change and the ‘learning on the job’ culture that has mostly informed their practice. Over time, the continuing change and learning that has occurred, has provided nurses time to reflect and to consider opportunities for improvement in terms of preparation and support as they experience it.

Learning on the Job

Learning on the job or experiential/informal learning of cultural competence was a repeated theme across the interview narratives. Nurses described their acquisition of

cultural knowledge (generic and specific) as being mostly derived from responding to the needs of ethnic minority service users and noted that it took place within a relatively short period of time within the locality.

“Oh I’d have to say it was all informal...from experience...the best way [laughing] ...nothing like being thrown in at the deep end”! (P3)

Some nurses linked the value of their own personal development and life experiences as being beneficial to work based scenarios. This was mentioned mostly by nurses who were older and nursing for longer in the area.

“Oh I can safely say I was ill prepared....I think I had a lot of life experience behind me as a nurse and personally and I think that definitely helped...” (P5)

Nurses placed particular significance and value on the learning they gained from working with people within ethnic minority communities. Nurses acknowledged that a willingness to learn from the clients was a major factor in how they acquired and continued to gather information and skills.

“ ...probably from the people themselves....I think it’s a bit easier over the last number of years...I think it was harder at the start to get information...” (P4)

Nurses were keenly aware that knowledge builds up over time from engagement and interactions with people. In the absence of formal structures to acquire specific transcultural knowledge, the sharing of information sourced from clients primarily informed nursing practice and the local service.

“ I was lucky I had a load of African mothers in one area and to be honest we’d spend ages talking and getting to know things.....I’d share this around with the girls and other mothers...”(P5)

Findings demonstrate a primarily self-taught body of knowledge and skill with minimal formal, transcultural theoretical input. The following excerpt portrays a typical explanation, demonstrating ability by nurses to integrate experience and share informal learning in an effort to develop culturally competent practice.

“ In the beginning we would have talked and discussed cases amongst ourselves....we would know girls [nurses] in other areas around and we’d contact them too...looking for ideas and what they’d do.....some of us had experience from working in London and elsewhere and that was helpful...” (P7)

At the practical, superficial level there is evidence that nurses appear unsure of how to perform culturally appropriate care and where to access evidence-based information on transcultural nursing. Although nurses displayed elements of transcultural nursing, when asked about it a formal area of study and practice, they were mostly unfamiliar with it.

"I'd stab a guess at it now based on my experience...but it wouldn't be a text book definition [laughing]...I think over the years myself and the girls have come familiar with it...Is that what you call it [laughing]"? (P5)

"Well I've never studied it [transcultural nursing] but you know nursing is like that...sometimes you learn best from being immersed in the reality...grass roots back to basics stuff..."(P4)

However, while perhaps unaware of cultural competence health care theory, some nurses through their own experiences were applying their own informal explanatory models of care in practice.

"It's like anything really sure the people themselves are the real experts...it doesn't cost much to tap into that and learn stuff...I find people like when I ask questions about how and why they do things they way they do....then I can understand better" (P10)

On describing experiences of education and training for working within a culturally diverse population, those nurses who had some input spoke of a piecemeal or ad hoc approach to continuing professional development in this area.

"Lunchtime talks really, that was it. We had three or four of them here in the centre at one time. Yeah they were useful. I would have found them good but that was the only kind of training or information we got as such from the point of view of anything formal..."(P9)

Significantly, none of the nurses had received or undertaken any formal or recognised specific transcultural nursing, cultural competence education or training prior to or during their current position.

"No I can honestly say in any of my training or programmes I've done even to Masters level it would have been only discussions in class...you know amongst ourselves maybe and with the lecturer... but nothing formal...like not a specific subject....most of the experience I have was gleaned from the people themselves...yeah...on the job [laughing]"(P6)

"We haven't really had any specific nursing or community health training input...there must be information specific to our role and working with non-

Nationals...no...maybe just occasionally on Traveller health issues...but in general no..." (P4)

For some nurses, the only opportunity for preparation and information related to transcultural health care were generalised workshop type study days or conferences on cultural diversity issues. These were offered mostly by voluntary organisations within the non-governmental sector on related issues such as Female Genital Mutilation (FGM), Refugee/Asylum Seeker health and wider issues on human trafficking. Nurses felt these events were informative and useful but stated they did not provide specific health care information explicitly relevant to their practice.

"We had a training day on cultural diversity with a group in the city....but it wasn't very health care based....it was useful though...to find out other issues like accommodation, welfare and racism and stuff...but nothing else...nothing nursing related..." (P2)

Other nurses in this study responded pragmatically to their situation and felt that quick fix solutions would be useful. Nurses referred to resource manuals and on-line sources they could access quickly to avail of information about different cultures. However, there is some concern that these types of resources can contribute towards stereotyping of individuals and communities and in the long term are not overly valuable to the development of cultural competence.

"It would be great if there was one book or reference or something they could give us" (P10)

"It's having the time really...I know it sounds awful...but time is a big factor" (P5)

Significantly, for some nurses there appeared to be a detachment between their own individual professional obligations and motivations to acquire relevant information. They seemed to place the responsibility for acquiring transcultural information with the organisation and nursing management. This raises some questions in the context of their cultural desire to apply appropriate care and willingness to view their cultural competence development as a process and an outcome.

" I suppose if I needed it [specific cultural knowledge] or went looking for it I'd find it...but I haven't been told do otherwise....I talk to my colleagues and speak to the people themselves...that's basically what I do" (P1)

“I feel we should be made aware of these important cultural bits of information” (P3)

However, not all nurses were of this view. While most of the nurses described learning on the job, others acknowledged the need to combine this with some theoretical component.

“Well we talk about nursing and health care being evidence based...this is no different really...I know there must be a lot of stuff out there...we really should be accessing that type of information...but I guess it’s pretty new here...” (P6)

Although there is some evidence of a will to acquire theoretical transcultural knowledge, it is described in terms of aloofness and distance – where this information is at a remove from their professional roles. Another factor tends to be the excuse of time and the excuse that cultural diversity is new to Ireland. In addition, an over reliance on management and the organisation to provide this information is evident. This calls into question personal motivations in the context of the subject matter.

Some of the findings and evidence from this theme of preparation are closely linked to nurses’ experiences of support in the work place. The following section will explore some of these connections.

Feeling Supported in the Workplace

In answering questions and outlining their descriptions on workplace support, responses from interviewees were mixed. In the main, nurses outlined different experiences with varying levels of support from nursing management and some nurses clearly acknowledged support they had received and continue to receive. Some made reference to supports having changed over time and appeared empathetic and understanding of the learning process that was occurring for all (nursing management and nurses) in the community context at the time.

“If you had asked me that six or eight years ago I ‘d have to say they [nursing management] weren’t supportive but then it was because they didn’t know themselves and we were all learning...” (P2)

“ I was always making the point that if you’re working with more ethnic groups that needs to be taken into consideration [by management] when the case loads are being allocated...and it wasn’t necessarily that way...I felt like it was falling on deaf ears...but it’s improved a bit now....” (P5)

In acknowledging support, nurses were also aware of the limitations that nursing managers may have been exposed to, in seeking additional resources to provide the most appropriate care needs of a changing population.

“Well when I started here first, I was more-or-less on my own....I didn’t really make an issue of it...after a while as the area expanded and a lot of non-Nationals moved in....and nursing management became more aware of the needs....but they were learning too and up against it from the powers that be...I guess they were supportive that way, as much as they could be....” [laughing]” (P7).

However, for some nurses this lead to reluctance in seeking support and perhaps this understanding also contributed towards a lack of motivation to implement change. A minority of nurses never sought support from colleagues or from nursing management.

“I don’t think I feel I could ring any of my bosses ...to be honest I don’t know if they are resourced themselves to deal with it...” (P1)

“I would say there’s not all that much support. In public health you’re pretty much on your own anyway unless you go looking for help...” (P6)

It is not clear to what extent this impacted on their practice but arguably it could have resulted in poor care and the isolation and exclusion of clients. It raises questions about professional responsibility and reflectivity. It may demonstrate a culture of blame where staffs feel unable to express any limitations or equally it may originate in earlier experiences of not feeling supported.

“You know it’s just your job and you get on with it...I never went looking for much support...” (P5)

While these nurses might be culturally aware, their attitudes and subsequent behaviour demonstrate a lack of will or indeed ignorance of the cultural competence process and hinder movement to the next stage of their cultural competence development. It might reflect an attitude that these patients should be grateful for what they get and “when in Rome do what the Romans do” or it might reflect wider public discourses and approaches such as assimilation and tolerance. In addition, it may also reflect an attitude of disempowerment felt by nurses. Nonetheless, it raises professional competency and leadership issues in the context of teamwork and

accountability in community nursing and underlines the need for support and supervision.

In the main, nurses appear to feel supported by their local nursing management and structures. Importantly, regardless of actual supports, they are confident with the level of access available to nursing management when required. However, it is evident that there was no systematic approach to implementing specific transcultural supports and resources for nursing staff.

“To be honest we’re well supported...we can always make contact with our line managers or director...now they may not know specifically about a particular cultural issue or immigration matter but they will try find out and get back to us...” (P10)

It is evident that respondents feel the nursing service has been on a learning curve and tend to make allowances for this. However, it must be noted the possibility of positive research bias may exist in responding to this aspect of the study, as some nurses may have associated me with nursing management structures, due to my nursing grade equivalency and line management reporting structure.

Nurses described their experiences of support from HSE general management as being significantly different from that which they experience from local HSE nursing management. In the broader context of the HSE organisation, most of the nurses appeared to portray themselves as somewhat disconnected and detached from wider (non-nursing) organisational management.

“ You know, I must be honest but the HSE as an organisation is huge and all the recent changes have made it more difficult to keep on top of things...community nurses I guess aren’t really a priority on the communication or support ladder...it’s like another world [laugh]” (P10)

“I don’t know if HSE management would be all that bothered really to be honest. I suppose you sort things out with your colleagues and line managers...like if a report needs to be written you type a report and you send it in...I guess that’s how it goes” (P4)

Such findings are not unusual, as nurses would rarely have day-to-day interactions with general management. Therefore, experiences of community nurses feeling supported or resourced by general management (non-nursing) tended to focus on more administrative and remote experiences. The above extracts demonstrate a

particular understanding by nurses of the impact of general HSE management decisions.

This study coincided with a period of significant public health service transformation and reform in the Health Service Executive. Subsequent fiscal and health budgetary conditions, including a staffing moratorium (staff embargo), were also implemented during this period. Nurses expressed continuing frustration and questioned whether improvements in the delivery of services had occurred at all over the past decade and these concerns were mostly associated with general management

“Sometimes...on the ground here...it just still seems to be a bit all over the place...but I guess in other ways we’re dealing with the change head-on” (P10)

“You know we’ve been experiencing different cultures for the past ten years or more and why still are we struggling with a lot of cultures...” (P3)

These responses hint at dissatisfaction and frustration in terms of feeling supported in a general way. When it comes to feeling supported in the work place, nurses appear to rely on each other rather than on managers or organisational leaders for support. Unsurprisingly, the evidence suggests that community nurses tend to remain aloof from wider health service management and to seek direction mostly from nursing management structures. However, if real change in cultural competence is to occur in nursing services, it requires a whole organisation approach with engagement by all levels of staff.

“It’s probably easier to talk to your colleagues here and bang it out a bit and then come up with a solution...I suppose you sort it out amongst yourselves” (P4)

“Yeah....I think you rely more on your colleagues than you do certainly on management because sometimes management are very much not so on the ground regularly and don’t know what you’re trying to achieve....or they’re not aware”(P3)

Opportunities to Reflect in Practice

The data has revealed that nurses in this study operate from a minimal level of cultural competence. Although they are developing, the evidence suggests their

acquisition and cultural competence development has been ad hoc and passive. Yet it must be borne in mind that for the majority of nurses, this study provided for the first time, a limited opportunity for them to reflect on their transcultural experiences. It has revealed that they need more encouragement or direction to develop, as was evident at the time the data was collected. Consequently, these findings are unique in the context of how public health nursing is developing and adapting to cultural diversity in Liffeside HSE area and will be beneficial for future planning of services and continuing professional development of nurses.

In considering cultural awareness, it is interesting that some nurses in this study, at an individual reflective level, felt it necessary to suspend their cultural selves within their nurse-client interactions, while others felt it was important for them to work in accordance with their own personal cultural norms and values.

“I think I’m pretty open...I think you have to go in with an open mind...and pocket away your own values and beliefs at work and go in as a blank canvas and don’t have any preconceptions... it makes it easier...OK my beliefs are my beliefs and personal...but they do influence you [laughing....pause]...because at the back of your mind your always saying...Oh! If she’d only do it this way!! You have to move beyond that...” (P3)

“...my beliefs are my own... and I can’t just drop them...they’re part of my DNA [laughing]....and at times that’s hard...” (P10)

The above extracts portray the complexity and multidimensional aspects of developing cultural competence through having regard for our own cultural awareness. A key ingredient is personal and professional reflection on the dilemmas and challenges faced by nurses and an awareness of cultural imposition and ethnocentric attitudes and behaviours that can influence healthcare outcomes.

A minority of the nurses interviewed mentioned the impact of working with clients from diverse cultural and ethnic backgrounds and how this had made them think differently about culture and health.

“You know...I find myself looking at how people live their lives....I find since meeting more families, I’m more aware of the need to understand where they’re coming from...I don’t mean physically. You know to try and understand their values and ways...this is important for me as a nurse working with them.” (P5)

However, while most nurses welcomed the professional challenge of working with a changing population, the opportunities for structured and fruitful reflection appeared minimal in the work place.

“So often we’re just rushing in and rushing out....in some ways it’s a shame coz we don’t get to think about how we’re interacting.... it does affect you.....some time and space would be great for thinking and talking about this stuff....” (P7)

It must also be borne in mind that the nature of the public health nurse’s role is predominantly one of a lone worker in a home care context and differs from the acute hospital setting, where proximity to other staff and colleagues is constant and fixed. Very often, this physical isolation from colleagues and others in the primary care service can impact negatively on feelings of support and can reduce possibilities for team reflection, discussion and analysis of informal learning.

“It’s really only if an opportunity arises that I’d get to talk to one of the girls [nursing colleague] about things....we rarely get to sit down and talk constructively about these things...it would be good though...(P10).

It is evident from these findings that varied experiences exist, and they can appear incongruous and difficult to explain at times. In the main, nurses stated that they tend to support each other; however, they rarely seem to get the opportunities to physically meet up together to share information and offer moral and professional support.

From my experience of developing my own cultural competence as an insider researcher, I could relate to this sentiment and empathise with the nurses at times. However, at other times I found myself frustrated and angry, both in my reactions and how I processed my feelings in response to their contributions. Yet I was reminded of the earlier days, establishing my role as CNS with Asylum Seekers and to some extent even now, how I often experienced the need to feel supported by others who could understand the nuances, complexities and challenges of working in a very much isolated and non-mainstream health service. This is something that I have had to work on carefully in recent years, through reflection on my own learning within my role and in understanding the importance and value of leadership skills and knowledge. With supervision and support I have found this research process an empowering experience in assisting further development of my own cultural competence. In many respects I am aware that I am still ‘becoming’ culturally competent as explained by

Camphina –Bacote (2003) and that this process is a life journey of learning along the cultural competence continuum (Cross 1989).

Recent developments in the HSE and the establishment of primary care teams and health and social care networks may improve this situation and provide opportunities for nurses and others to reflect and support each other collectively on transcultural issues. Based on the evidence emerging from this study, it is intended that we undertake this journey together in planning for cultural competence development in the Liffeside area. A number of recommendations to assist in this regard will be outlined in the final chapter.

Chapter Six: Discussion of Study Findings

The aim of the study was to investigate the levels of cultural competence of community public health nursing staff by exploring their experiences of transcultural nursing. The context for the research was the rapid demographic change in cultural diversity within the local population of Liffeside health service area. Where the data allows, evidence and discussion is presented, relevant to individual and service level change. Three sources of data were used to address the research questions:

1. A review of literature relevant to transcultural nursing and cultural competence in health care in the local organisational and Irish context.
2. Findings from the Cultural Competence Assessment Tool (CCAT) survey with nurses working in Liffeside health service area Dublin.
3. Findings from the semi-structured interviews with nurses working in Liffeside.

My discussion will be presented using the key themes that emerged from the study where findings can be supported or opposed by the quantitative and qualitative data. The discussion will be outlined based on the interpretative methodology and design, with reference to the original research questions (outlined below).

1. What has been the experience of nurses in responding to a change in cultural and ethnic demographic in their local population?
2. What are nurses' understandings of cultural competence and transcultural nursing?
3. How prepared and supported are nurses in delivering transcultural care to an ethnically diverse population?

While occurring within a work-based context, the application of transcultural nursing in practice requires personal and professional awareness and the acquisition of knowledge and skills. As an 'insider researcher', I acknowledge and value the contribution to be made from my observations and the experience I have gained from my own position as a community nurse. However, I am also cognisant of the limitations this may impose. Therefore, while efforts were made by me to reflect on

my learning and to remain impartial in the planning, undertaking and analysis of the study, some negative and positive bias can be anticipated.

In addition, as this is a local study, the findings do not claim generalizability to the public health nursing service nationally; however, the findings may be broadly applicable in other health and social care settings and professional disciplines.

Theme One: Experiencing change in local population

In describing their experience of change in Liffeside community, nurses stated their most common starting points for engagement with ethnic minority clients were maternal and child health interventions. Interestingly, they referred to patterns of settlement they experienced with people over time. For example, nurses referred to encounters they had with ethnic minority first-time mothers when visiting new born infants. Many commented that they encountered the same children again, years later, when practicing in their primary school nursing role. This seemed to surprise nurses and was mentioned in their descriptions as an almost unexpected possibility.

As the researcher, I had not anticipated this lack of awareness by nurses of how global issues impact locally. I was reminded of my own bias in that I was considering this study through a development studies context. Although these experiences by nurses confirm local authority data that indicates a significant percentage of ethnic minority families are choosing to remain and establish their lives in the Liffeside (Fingal Development Board 2009, Ryan 2009), this type of finding raises questions about nurses' understanding of the migration and acculturation process (Berry 2002).

For example, it appeared that ethnic minority clients and other types of immigrants were regarded by nurses as only temporarily residing in the area. This may then have influenced their interventions, relationship building and engagement with clients. However, on reflection, this type of thinking and attitude was not unusual. It corresponds with descriptions of the Irish public's general understanding and response to inward migration and cultural diversity from the mid-1990s and mid-2000s (Lentin 2002, Mac Einrí 2007).

This finding also reveals that the experiences of nurses reflected the pace of demographic change and corresponded with the literature and evidence from other sources on population demographic trends in Liffeside and the region as a whole (Ryan 2009, Skokauskos 2010, CSO 2007, CSO 2011).

The experience of change in local population is particularly important for the following reasons. Firstly, it is the first time a specific study on cultural competence has been undertaken in public health nursing in the HSE, gauging nurses' experience of rapid cultural change and the impact of unprecedented and rapid growth in population on nurses working in the area. By experiencing the demographic change in the area, nurses were becoming exposed to the health and welfare needs of ethnic minority families throughout the lifespan. However, in the context of developing cultural competence, the CCAT evidence also revealed that nurses were limited in their levels of specific cultural knowledge and appeared to lack confidence in this aspect of their practice (as was later confirmed by the qualitative data). This is not surprising given the rapid nature of the change and the subsequent attempts by nurses to respond and meet the needs of the emerging diverse population.

In the main, nurses were responding to the postnatal care of mothers and consequently their primary focus was the delivery of generic maternal and child health information. Therefore, it is understandable that culture specific approaches might not be readily accessible but expected to follow later. However, the data revealed that this was dependent on factors such as motivation, access to information, resources and support. As none of the nurses in this study achieved a level of cultural competence, it must be considered that cultural specific knowledge has not yet materialised and one must question why.

The change in local population revealed some evidence of nurses dealing with elderly ethnic minority immigrants. Although rare, this too corresponded with some of the official statistics on population changes (CSO 2007, 2011). This suggests the need to plan and develop culturally appropriate services that reflect the needs of the whole community over the lifespan. Nurses were surprised to meet elderly people of diverse ethnicity in need of community nursing services and they appeared hesitant and lacking in confidence in how to respond. Their descriptions of these rare encounters with older immigrants revealed interesting and sometimes contradictory insights,

arising from ethnocentricity and unconscious stereotyping. The finding also reveals a lack of awareness by nurses of the complex factors that impact on immigrants of all ages, such as the need to seek asylum or protection.

However, there was evidence of some nurses thinking on their feet in terms of how best to support clients and families. Nurses were concerned at times and demonstrated sensitivity about how new immigrant mothers or elderly immigrants may become isolated and less integrated in the local community. However, nurses felt they were mostly lacking in knowledge and were at times frustrated. This understanding by nurses raised questions for me about how they viewed and approached their nursing role in context of cultural competence. For example, it appeared to me that they were operating from a medicalised model that failed to consider wider social approaches. They had failed to consider how the wider family or community might have been developed to provide culturally appropriate and more accessible support (Baisch 2009).

This study did not set out to explicitly investigate changes in population or specific global health issues associated with ethnic minority health. Yet, it is of relevance that these factors have emerged from nurses experiences of working in the locality. The data tends to explain the reactionary nature of work that nurses were engaged with due to the change in local population.

Even though nurses in the study have described their experiences as being informed by knowledge and awareness, the data reveals a limited understanding by nurses of issues such as migration and cultural diversity and their positive and negative impacts on health outcomes for service users. Similarly, nurses drew attention to physical and/or psychological health effects encountered by some clients; yet they also expressed that they felt ill equipped for dealing with these types of situations. Of more concern is the fact that they demonstrated a minimal level of effort about informing themselves.

While some nurses perceived their work with the culturally diverse clients to be appropriate to meeting their needs, others were of the opinion that new groups should adjust to fit-in within existing services and assimilate. In many respects this revealed an air of tolerance, rather than one of inclusion and equality (Husband 1994, 2007).

Therefore, the findings raise further questions for nurses in Liffeside, challenging the current status quo and underlining the need to establish how the nursing services can best change to meet the needs of the whole community. These are questions to be asked of nurses who perceive themselves as doing the best they can and who consider themselves personally and professionally sensitive.

The data did reveal that nurses are under constraints and often lacking in resources but have developed some level of cultural competence development. However, tensions and ambiguity were evident. The findings demonstrate an incongruity in nurses' understanding of how they ought to respond to ethnic and cultural changes in local populations. In the main, nurses appear to respond to other demographic variables that occur naturally in their work environment, such as an ageing population, child health, Travellers health. What is not evident is their ability (or willingness) to respond to immigration and cultural diversity with the same level of appropriateness.

Thus far, in the context of working in a globalised world and healthcare environment, the findings from Liffeside raise a number of issues relevant to the public health nursing. For example, a nurse should be reasonably expected to be aware of and respond professionally to, transcultural health issues encountered in their workplace. However, it is clear that they must be developed and empowered to respond appropriately. Perhaps more importantly, we need to consider the motivation and desire of nurses and staff to develop cultural competence and help to prevent complacency which originates in ethnocentrism and manifests as prejudice in individual practice and service provision.

Theme Two: Racism

This study did not set out to specifically investigate racism in community nursing. Yet racism as a form of direct or indirect discrimination at individual and institutional level emerged as a key theme. Although nurses did express negative feelings at times about people from ethnic minority communities, they stopped short of naming these feelings, attitudes or practices as racism / racist. Indeed, nurses failed to explicitly mention racism as an issue in their practice or work environments until it was named directly by me through probing questions during the interviews. However, evidence of overt racism was very rare and where mentioned, experiences of racism were

described as occurring outside of nursing. This finding will be discussed in further detail later in this section.

It is probably not surprising to see racism reported in this study, as it reflects the reality of demographic change and the subsequent public social issues which it evoked. It also corresponds with evidence from the wider literature where avoidance of talk about race and racism in nursing and health care remains common (Gustafson 2005 Culley 2006, Cross-Sudworth 2007, Tilki et al 2007). However, it is new and unique in the context of public health nursing in the Irish health services.

Healthcare and those who work in it are not immune to those social and popular influences that shape people's understandings and interpretations and ultimately shape our attitudes and behaviours (Smith and Lorenzton 2005, Fanning 2011). What was interesting in this case was that nurses did not appear to consider any implications for themselves in relation to 'non-action' in the context of experiencing or responding to racist incidents. In the main, the accounts by community nurses portrayed a level of racism and discrimination that was manifested primarily as unconscious and inadvertent racism, both at individual and service level (institutional). It appears that nurses predominantly operate through an ethnocentrism that reinforces perceived stereotypes and prejudices. Nurses did not seem to relate their transcultural experiences to any reflective understanding of racism as an issue that can affect or determine the outcome of their interventions. Similarly, when describing their experiences, nurses did not explicitly mention or demonstrate an awareness or understanding of the impact of racism on their clients' health and wellbeing. The vast majority of nurses (80%) in the CCAT; however, acknowledged that discrimination and harassment in everyday life leads people to engage in behaviours which may be damaging to health.

Consequently, the findings reveal an inconsistency, tension and indeed a contradiction about racism when compared to the CCAT survey findings. These demonstrated that all of the nurses (100%) surveyed, acknowledged and strongly agreed that subtle forms of racism are as damaging as overt forms. Additionally, the majority of nurses surveyed (92%) accepted that institutional racism is seen in unwitting prejudice, ignorance and thoughtlessness. Yet, the experiences outlined from the interviews portrayed a different reality and demonstrated that nurses were reluctant to even name

and acknowledge racism in their practice. This tension may serve to explain in some limited way why 58% of nurses did not feel confident to challenge racism in the workplace. However, how can this be explained? For example, nurses were concerned about the inequality they perceived in service delivery and about the lack of provision of interpreters, yet the majority did not refer to this as an indirect form of institutional racial discrimination. There is clearly a lack of awareness by nurses of institutional racism and how it is constructed and understood or indeed how they themselves unconsciously contribute to it. In the context of understanding racism, the findings of this local study bear some similarity to the issues identified in the Stephen Lawrence Inquiry (Macpherson 1999). The evidence demonstrates that nurses are unaware or unconcerned about the institutional racism to which their clients are exposed to. More importantly, definitions aside, they appear unwilling to challenge the failure to provide adequate services for their non-Irish clients and are content to provide less than perfect care for them

As racism is a sensitive issue and is constructed primarily from personal experiences and social interactions, it is understandable that nurses were reluctant to reflect explicitly, openly and honestly at interview (Robson 2002, Sliverman 2010). Despite reassurances of confidentiality and anonymity, nurses may have been embarrassed or feared implicating themselves as having standards unbecoming of a nurse in accordance with the Code of Professional Conduct for Nurses and Midwives. For any healthcare worker, to consciously acknowledge their racist attitudes or behaviours or their complicity in other forms of discrimination, calls into question not just professional ethical standards but also one's own personal morals or ethical ways of being. Therefore, reflecting at a human empathetic level, I was not surprised with the response from participants.

As an insider researcher, I may have been perceived by participants as an expert in the field and this may have influenced some of the respondents. Perhaps they aligned themselves with politically correct responses by telling me the answers they thought I would want to hear.

The evidence from the transcripts suggested that nurses carried on, rarely if ever, critically reflecting on racism and forms of discrimination in their own individual practice or within the service.

It is difficult to extrapolate meaning from these incongruous and sometimes contradictory findings. While, in the main, nurses' responses seem to indicate they are not intentionally creating barriers, the question must be asked as to why nurses engaged in a type of distancing of themselves from the issue of racism.

The data demonstrates that nurses rarely mentioned solutions or alternatives that included themselves as proactive leaders or sought knowledge that would be helpful and / or beneficial in this regard. It may be that nurses simply did not want to draw attention to themselves or their lack of knowledge. To admit this, might have exposed them as being insensitive and ignorant to the needs of culturally diverse clients.

As a means of self preservation and protection, they continued to work in ways they were used to and had been socialised into and which had become the established norm. It was easier and less burdensome to maintain the status quo and it not did pose any risk to them, as these clients were less likely to complain. It is also possible, that in a stressful environment and perhaps feeling less competent, not getting involved was also a way of coping. This finding is in keeping with other studies that have considered the ways in which health professionals carry out their work, particularly those engaged in emotional labour or psychologically demanding areas of healthcare (Menzies 1960, Smith and Lorenzton 2005, Gabriel 2010). However, this finding is new and unique in the context of cultural competence in public health nursing in the Liffeside HSE service area but has resonance with the wider literature.

The significant dearth of scientific studies or commentaries emanating from nursing and professional health care practice in the HSE that address race, ethnicity and cultural diversity (apart from the Travelling community) has some significance in these findings (Touhey et al 2008, Lyons et al 2008, Donohue 2010, Markey et al 2012). This may go some way towards explaining the lack of awareness and commitment in addressing racism and discrimination in nursing and healthcare in Liffeside.

Although there is robust equality legislation in Ireland that covers racial discrimination, there is no legal obligation in place on public services or staff to report on actions, outcomes or targets that counteract discrimination. Indeed, the absence of a national ethnic equality database in health care is a significant gap and is likely to

influence health care professionals' knowledge and health service responses in this area of health care. Therefore, when compared to other health service jurisdictions, such as the UK, levels of accountability are inconsistent in the Irish context as evidenced in this local study.

However, these alone cannot be used as excuses for the prevalence of the different forms of racism presented in this study. Cognisance must be paid to individual, social and organisational influences. This requires an educational and professional response, as limited understandings of racism and a lack of knowledge on how to combat it, can conspire to further isolate or exclude people. The evidence from both sets of data demonstrates that, in the main, the approaches to work by nurses in Liffeside are not intentionally racist but are a reflection of ignorance, unconscious prejudice or stereotyping and if not addressed can become institutional racism (Tilki et al 2007). The lack of commitment towards addressing less than adequate care is a further dimension which chimes with other studies and needs serious attention. Fanning (2007) comments that racism has never been solely about the actions of individuals, claiming that it finds expression in the rules of organisations, social norms and that legislation addressing racist acts, whether intentional or not, is essential to the development of cultural competence. The forms of discrimination that produce unequal outcomes are often covert and unintended.

On reflection, the palpable unease and discomfort of participants when discussing racism was a mitigating factor for further in-depth exploration by me. At the time of interviews it highlighted ethical considerations that as the researcher, on occasion, made me feel uncomfortable and lacking in confidence in how to proceed. I did not consider racism to be an area of my own specific expertise and where necessary, any concerns, including feelings of uncertainty, that arose and possible precautions required on my part, were discussed and resolved with my academic advisor.

Ethically and professionally, I felt I required further reflection and personal preparation to build knowledge and confidence in this specialist area before addressing it with others. In investigating strategies to combat racism in healthcare and nursing, Tilki et al (2007) and Markey et al (2012) emphasise the importance of a structured and safe, supportive environment, to enable health care staff to reflect personally and professionally over time with an experienced facilitator. As the

research process advanced, I became more conscious of this omission as a limitation of the study, as it did not allow for support and ongoing facilitation for participants.

Theme Three: Focus on Difference: ‘They and Them’

The evidence from both sets of data revealed that nurses in Liffeside demonstrated a concern and willingness to engage and interact with service users from ethnic minority communities. However, it raised further questions about their understanding of culture and ethnicity and concerns about at what level were they prepared to meet the needs of clients from ethnic minority backgrounds?

The overall CCAT evaluations indicated that all participants were culturally aware and the vast majority of nurses considered themselves to have high levels of their own ethnic and cultural awareness. However, evidence from the interviews revealed tensions in this regard. Interestingly, when the statement scores of the CCAT survey in the cultural awareness domain were compared to the self-assigned VAS scores, nurses had an elevated opinion of their own levels of cultural awareness. While it is understandable that nurses were keen to portray themselves as culturally aware in delivering what they perceived to be culturally appropriate care, this finding also warrants caution. While these findings demonstrated acceptable levels in the cultural awareness domain of the CCAT, they also indicate that nurses may at times, have a misguided understanding of their own cultural awareness. Consequently, practices may be inadvertently influenced by unconscious ethnocentric attitudes that go unchallenged in the work place.

Although working hard and thinking on their feet in their day-to-day practice, the evidence thus far disappointingly suggests that, in the main, nurses are not motivated or knowledgeable enough to move beyond cultural awareness and seem content to just get by. This therefore has consequences in how nurses view people in their care and how they respond to cultural diversity. Qualitative data from the interviews and subsequent interpretation of the transcripts revealed types of language and uses of terminology by nurses that placed a particular emphasis on difference. In the main, it is fair to say that these descriptions portrayed an ‘othering’ of ethnic minority clients, that tended to originate where community nurses were operating out of an unconscious level of cultural incompetence. If nurses continue to focus primarily on

difference, they may not move beyond this impasse and therefore may not achieve cultural competence practice levels.

All of the nurses interviewed mentioned that people from ethnic minority backgrounds were 'different' and at times participants regarded these differences as barriers. However, some inconsistencies also emerged. For example, 75% of nurses surveyed agreed that people from ethnic minority groups share many of the same values and beliefs as people from the host country. However, in the qualitative data, nurses made little or no mention of these commonalities and similarities when outlining their transcultural experiences. This raises questions about how nurses attempted to understand these differences. It appeared that nurses were establishing a 'distance' between themselves and ethnic minority clients by focusing too much on difference. It also seemed they were unaware of this, let alone its implications in the delivery of care.

In attempting to understand and explain this finding, one must consider the social construction of cultural identity in response to unprecedented levels of inward migration and increased cultural and ethnic diversity in Irish society over the past decade. The politicisation and racialization of language, attitudes and behaviours that occurred within the public domain during the period of mass immigration had significant social impact (Lentin and Mc Veigh 2002, Fanning 2011). As members of society, the nurses in this study were working in one of the most culturally diverse areas of the HSE and therefore, were not immune to such influences. It is likely that this could have informed their personal and professional understandings and subsequent attitudes and behaviours.

Although keen to demonstrate that nursing is practiced in accordance with the norms and values of empathy, respect and trust, the data revealed a tension in the capacity of nurses to communicate this expectation in the cross-cultural context. Using an interpretative approach, I was aware that language plays a key role in the development of meaning and in expressing such understandings in any research process that explores people's lived experiences (Van Manen 2007). Therefore, in my analysis of the findings, the interpretation of the language used by the nurses was central in attempting to extrapolate meaning from their experiences.

The use of language and terminology when describing their experiences tended to indicate a distancing or “othering” by nurses. The healthcare literature demonstrates how this type of narrow understanding can have implications for clients and health service providers and may result in negative healthcare outcomes for people from culturally diverse backgrounds (Bhopal 2007). Generally, there is a failure to challenge people’s attitudes, perceptions and behaviours at a personal or professional level (Fanning and Mutwarasibo 2007, Husband 2007, Markey et al 2012). The evidence suggests that nurses in this study are not immune to the effects of such influences and that they can inform their opinions and attitudes either consciously or unconsciously.

The confusion and uncertainty in the use of language and terminology, most likely contributed to nurses’ unwitting ethnocentrism. For some, this manifested as a tension that led to a lack of confidence in how they interacted and engaged with ethnic minority clients. During the research process, nurses understandably did not want to appear ignorant or unprofessional. It was apparent they wanted to do the right thing and describe experiences ‘correctly’ by using the correct language and they were fearful of not using the ‘correct’ language and terminology. Some participants acknowledged they did not understand definitions associated with cultural diversity and did not want to offend people’s sensitivities.

The evidence shows that the terms ‘*them*’ or ‘*they*’ were used the vast majority of times by nurses, when referring to people of ethnic minority. This clearly placed an emphasis on difference. This ambiguity and apprehension about the use of terms led to nurses having some contradictory understandings and tensions, seeing ‘them’ as different but treating ‘them’ all the same. In using these terms and types of language, nurses may not have been aware of ‘othering’ and ‘stereotyping’ and the consequences that can arise (Papadopoulos 2006, Kai 2007).

The use of language, either consciously or unconsciously, by nurses must also be considered when interpreting the socio-political context of working with diversity. In this study, terms such as ‘*immigrant*’, ‘*asylum seeker*’, ‘*refugee*’, ‘*ethnic minorities*’, ‘*non-nationals*’, were all used interchangeably, indicating that nurses’ understandings generally tended to be inaccurate or misinformed. Interestingly, and disappointingly, in the main, the evidence from both the quantitative and qualitative data revealed very

limited efforts by nurses to acquire the relevant information and familiarise themselves with the appropriate use of acceptable definitions and terms. If ethnic minority clients encounter staff who demonstrate a lack of understanding or use inaccurate or possibly offensive terminology, it is understandable that people may withdraw from services or, at the very least, have little confidence in the staff they meet (Paez et al 2008, Fountain et al 2010). This has serious implications for the delivery of appropriate care and the health outcomes of minority clients. For example, it is important for nurses to be aware that, in the context of access to health care services, there is a difference between an asylum seeker and a refugee and the benefits and limited legal rights and entitlements assigned to these respective groups. Although in this study ethnocentrism mostly occurred unconsciously, if not reflected upon and left unchallenged, these attitudes and behaviours by nurses in Liffeside could negatively influence the health and wellbeing of ethnic minority clients in the community. Some recommendations to help address this will be considered in the following chapter.

While there are many examples contained in the data of well intentioned efforts, consideration of positive research bias must also be acknowledged, where nurses were keen to be seen to give the correct answers (Robson 2002, Silverman 2010). As the first step to cultural competence relies on understanding, challenging and articulating our own stereotypes, prejudices and biases, there was understandably a type of political correctness that nurses felt needed to be preserved in the discourse of their experiences. Furthermore, participants in the study may have perceived me as an expert in the field. In some of the interviews, nurses sought clarification from me on their use of terminology and language. However, it also conceivably demonstrates tardiness and a lack of will from nurses to have informed themselves. However, the data also revealed there was a lack of opportunity for nurses in their workplace to engage with safe and non-judgemental exploration of key concepts, constructions and meanings associated with the terminology and language used in this area of health care. Of course, nurses could have requested this information.

Interestingly, although the CCAT indicated that 79% of nurses surveyed agreed that there are many differences in values and beliefs within any single ethnic group, the qualitative data showed very limited evidence of this understanding. In the main, the

qualitative data demonstrated a genuine ignorance about the construction of identity and cultural self-awareness.

Participants had limited understanding about how ethnicity and culture can influence health and healthcare outcomes. Both sets of data revealed that nurses disagreed that people from ethnic minority groups have particular difficulty accessing community health services. Nurses, although unwittingly contributing to discriminatory practices, appeared to have difficulty identifying the health and wellbeing implications of forms of discrimination for themselves, service users and service provision. Of course, this is not unique to nursing but implicit in healthcare in general (Helman 2007, Donohue 2010).

In theoretical terms this may be explained in the context of nurses having a broadly defined but narrowly applied understanding of the concepts of culture and ethnicity, where little attention is given to the complex multidimensional nature of ethnicity and even less emphasis given to the socio-political aspects (Culley 2006). It is only since 2006 that ethnicity has been officially included on the Irish population census and the concept may not yet be fully understood.

For example, in the main, nurses inadvertently equated nationality, ethnicity, culture and in some instances religion with each other and demonstrated little understanding of other characteristics and variables such as language, social class, ethnic identity, religious, political or geographical affiliations. Although understandable in the context of the day-to-day application of practical nursing, it is this lack of awareness that can impair further exploration and reinforce stereotyping and ethnocentrism.

These findings may be explained and understood in the context of nurses operating out of a tolerance approach (Husband 1994, 2007). If the nurses' understanding of working with diversity is set within a tolerance paradigm, it must be acknowledged that this is no replacement for prejudice or bias. Indeed, it is worrying that, despite decades of research based policy driven by social inclusion models in the HSE (particularly in the context of Traveller health), notions of 'tolerating' the 'other' continue to persist in the context of the provision of services to newly established communities. Indeed, the experiences of Travellers in Ireland in the context of health outcomes demonstrates that prejudice, either conscious or unconscious, that is

replaced by tolerance, leaves in place a disempowerment and stigma that negates any real possibility of inclusion and integration (HSE 2008, DOHC 2010).

In considering this concept of 'othering', nurses in this study who had been immigrants themselves (79%) recalled their own experiences of living together in groups. Although this served their needs for safety, security, practical support, friendship and a sense of belonging and inclusiveness, evidence of this empathy was limited in the qualitative data. Only a minority of nurses referred to this personal empathy when describing their work with ethnic minority service users in the primary care context. The evidence suggests that nurses tended to problematize ethnic minority clients as service users rather than criticise the system of health care provided to them. In some descriptions, nurses tended to problematize the fact that 'they' (people of ethnic minority) all lived together in areas. Understandably, nurses perceived this as being problematic in terms of barriers to accessing services, poor integration with the local population and not learning English. Yet the qualitative data revealed evidence that was not always explicit, indicating there was an element of proportioning blame on immigrants who lived together in this way.

It is difficult to ascertain why this is so. Influencing factors may include nurses' close one-to-one working relationship with clients, making it difficult for nurses to step back and see 'the wood from the trees' (Gabriel 2010). In addition, as mentioned earlier, nurses are not immune from other social and public influences, media reports for example, that sensationalise and problematize migrants or ethnic minority members and further compound attitudes and behaviours in the work place that go unchallenged without any critical reflection (Tilki 2007). Although 'othering' is not new to nursing (Menzies 1960, Smith 1992) in the context of transcultural care, it acquires a level of complexity that is often informed by subtle and sensitive socio-political influences (personal and professional) that are an anathema to the principles and philosophy of nursing practice and health care.

The concern is that these attitudes and behaviours run contrary to professional community nursing care practices and the legal and ethical obligations of nurses. Consequently, it requires naming and addressing in a professionally sensitive and productive way, some of which will be considered in the recommendations chapter to follow.

However, the question must be asked as to why some nurses consider it appropriate that their professional interventions with ethnic minority clients should be no different to meeting the needs of the indigenous population.

An understanding of how nurses understand the concept of equality in their work with ethnic minority clients may help to explain these findings. By and large, nurses considered equality simply as a process of treating all people the same. However, and surprisingly, nurses appear unaware of the implications of this interpretation. As the researcher, I found this finding difficult to comprehend, as a general core principle of nursing requires that a nurse anticipate peoples' needs and awareness that different people and their situations may necessitate different responses to meeting the same need. Therefore, I found myself asking why nurses appeared to have difficulty applying this principle in caring for ethnic minority clients.

While in practice their understanding of equality may seem fair; in reality it is an oversimplified understanding that can have implications for clients. For example, as observed in the literature, opportunities of access determine equality. Equality is not about treating all people the same because different groups of people have different needs and different groups, including some people from ethnic minorities, experience discrimination in different areas of life and in different ways (Watt et al 2008). In transcultural health care and in efforts to eliminate health care disparities, treating everyone the same can constitute an indirect form of discrimination as some people have much greater needs than others (Betancourt 2006, Office of Minority Health 2013).

In considering focus on difference, albeit in a limited capacity, some attention needs to be given to the mono-cultural ethnic profile of community nursing in the area. Despite working in one of the most ethnically diverse health service areas in the HSE, no explicit evidence emerged from the qualitative data addressing the homogenous make up of the nursing workforce in Liffeside.

Perhaps the invisibility of ethnic diversity within the nursing service is an indicator of how nurses engage and interact with clients and indeed understand the concept of cultural diversity? Conceivably, it may be that working in a mono-cultural group provides very limited opportunities for nurses to professionally challenge issues such

as forms of discrimination amongst themselves. If not, the implications of this may be the continuation of entrenched, unconscious and unreflective ethnocentrism.

Furthermore, this portrayal of a mono-cultural workforce may impede efforts to connect with diversity and the experiences of health and healthcare held by others living in the area.

Although unique to Liffeside health service area, this finding is discussed in the literature. Diversity management in nursing services has been shown to be beneficial in developing partnerships that are empowering for health care staff and clients, with resultant positive health care outcomes (Brach and Fraser 2000, Baish 2009). However, it has also been observed, even where measures to actively encourage and support diversity management in health care exist, that change is slow and requires experienced committed leadership (Esmail 2005).

In most cases, both quantitative and qualitative data demonstrated that an over focus on difference by nurses is what came to define others. The evidence revealed how nurses unconsciously utilised their positions in (mostly inadvertent) ethnocentric ways, which ultimately restricted the critical and reflective development of cultural competence. In the main, practical solutions or actions addressing specific cultural issues were rarely implemented to nurses' satisfaction in the long term. This is an example of how critical thinking as a core component of transcultural nursing preparation would increase their confidence to confront such important issues in the primary care context.

Nurses who were immersed and busy in their practical tasks described examples of ethnocentrism and stereotyping when explaining some of their cultural encounters with service users. These generally tended to be portrayed without any conscious awareness of the ethnocentric nature of their experiences. Nurses failed to grasp that focusing on difference requires individual motivation, reflection and organisational change (Mc Gee 2009).

The findings from this study give rise to further questions in the local context and indicate that there is room for improvement. Education and legislation alone are insufficient in tackling values and discriminatory attitudes and practices that persist in the 'hearts and minds' of health care professionals and organisations (Culley 2006).

Nonetheless, in the context of this local study, it is important that nurses learn to be self-aware and reflective, to seek and to accept constructive criticism. This will enable them to reflect on cultural factors which may be misunderstood or misinterpreted and that contribute to stereotyping or ethnocentric care. Such approaches may empower nurses to become more confident in understanding and responding to diversity, including racism. It is evident that nurses in this study think on their feet, adapt to practical situations and offer what they regard as a good service. However, the evidence has also demonstrated that nurses have a limited awareness and seldom reflect on the importance of acknowledging and working effectively with diversity. These limitations play a fundamental part in the development of relationships and communication with clients and will be considered in the following section.

Theme Four: Building Relationships and Communication

The significance was not lost on the nurses in this study, that communication skills are considered the most basic of all healthcare professional's tools in assisting to build effective therapeutic relationships (Leininger 1995, Kai 1999, Helman 2007). However, in the main, the evidence from the data reveals some mixed and incongruous findings at times.

As expected, the evidence reveals that, at times, transcultural experiences for public health nurses in Liffeside posed significant challenges in terms of communication and building relationships with ethnic minority clients. All of those interviewed mentioned the importance of communication when working with ethnic minority clients with low or no English proficiency or comprehension. But interestingly, not all nurses felt that ineffective communication (for whatever reason) impacted on their relationships with ethnic minority clients. Consequently, nurses appear to have limited understanding of the implications of inappropriate and ineffective cross-cultural communication methods and their relevance to health care outcomes.

In the main, they seemed to understand communication as a language only issue, which involved the exchange of information through verbal and/or non-verbal means. For the nurses, their concerns in these exchanges were mostly with their efforts in the delivery and subsequent comprehension of information to clients. While this is an essential element of providing care, nurses mostly failed to consider that language is

but one component of communication and is constructed and learned within particular socio-cultural contexts (Robinson and Philips 2003, Helman 2007). Other social factors that may affect cross-cultural communication including age, class, gender, religion or politics were rarely considered by the nurses in this study. Solutions put forward by nurses tended to focus on access and use of interpreters whether formal (professional) or informal (family / friends).

However, at times the qualitative evidence tended to contradict some of the quantitative findings. In the CCAT, 91% of nurses clearly indicated that they believed health care practitioners should be trained in the use of interpreters and advocates. Yet the vast majority of the nurses interviewed had not sourced formal interpreters or training during their practice as community nurses in Liffeside. Furthermore, the qualitative evidence demonstrated that nurses had poor levels of knowledge about the existence of interpreter services in the HSE area and how or where to go about accessing them. Even though this is a new and relevant finding in the context of HSE Liffeside, in the context of general effective intercultural communication, it is not unique to nurses or health systems. Similar findings have been found in studies elsewhere, conducted with GPs who work in the community setting in Ireland and primary care services in the UK (Mac Farlane et al 2009, Kai 2007, Rosenberg et al 2007).

Other factors may impact on the overall communication dynamic and healthcare outcomes. For example, the interview data revealed that nurses rarely considered that ethnic minority clients, who may be undocumented migrants, could be distrustful or fearful of communicating with official health care staff. Therefore, if communication is narrowly viewed as a language only issue, without consideration of the cultural and socio-political influences, barriers can emerge in providing appropriate care. A consequence of which may be further social isolation and vulnerability for ethnic minority clients (Rosenberg et al 2007, Mac Farlane 2009).

Although these responses may be interpreted in the context of a lack of knowledge, education or training, they also raise questions about the motivation of nurses to follow through on appropriate communication supports and development of their capacity to implement change.

In the qualitative data, nurses mentioned a number of factors they considered as barriers (structural and organisational) to establishing effective communication with clients, such as cost and time constraints. However, it is worth asking that, if nurses were to use these factors as impediments to providing care to an English speaking Irish citizen, querying for example, the cost of a particular dressing required or the length of time it would take to apply, would these be considered valid reasons not to implement appropriate care by the nurses themselves? Hence, similar to the evidence in the previous sections, these communication findings again call into question why nurses are continuing to work in established inappropriate ways with ethnic minority clients?

Although the data reveals very limited insights and explanations by nurses about their own interpersonal barriers, difficult and sensitive questions must be asked. Is it because they can continue to get by? Is it because they are disempowered to affect change? Or is it that they simply are not willing? Either way, these findings demonstrate a particular and worrying impact on the development of therapeutic relationships and nurses' attitudes. Furthermore, unless addressed in a professionally sensitive and strategic way, they are likely to influence and compound already established stereotypical understandings of ethnic minority clients in Liffeside. Some methods and actions to help counteract these developments will be considered in the recommendations section later.

However, when both sets of data on building relationship and communication are compared, there appears to be ambiguous understanding by nurses. The qualitative data here tends to conflict with that from the CCAT survey. 71% of nurses scored themselves in the higher category of cultural sensitivity, of which 30% of nurses scored themselves the maximum 10 points on the VAS score (self assigned). Although this may indicate they were very confident of their ability to establish trust, show respect and empathy to all people whatever their culture, the qualitative evidence that emerged contradicts these findings. Nurses described experiences where they could not always 'click' or build relationships with clients, due to communication and language barriers but demonstrated little evidence of attempts to improve this type of situation.

Of particular concern is that nurses do not appear to fully consider the implications for themselves as professionals or their clients by not providing effective communication when required. Notwithstanding the possible professional clinical implications, such as sub-standard clinical assessment and possible misinterpretation or misdiagnosis, justifiably these types of scenarios can also expose nurses to being accused of discrimination or unfair treatment. However, it is interesting but perhaps unsurprising given the interpretation of equality commonly held by nurses, that they did not consider their role in the context of their obligations under the Equality Legislation.

While structural and organisational factors were cited by nurses as barriers to developing relationships, it is clear that attitudes and behaviours also influenced efforts and subsequent beneficial therapeutic relationships. Although not explicitly named at times, it was evident from the language used by nurses that clients were sometimes viewed as being problematic or awkward, simply because they could not communicate with them. For example, descriptions by nurses from the qualitative data demonstrated that they struggled, to the point of frustration at times, when communicating with linguistically diverse clients and with those with no English. While understandable, it is also not unreasonable to expect that professional nurses should be able to determine when to seek the services of a professional health care interpreter or to determine an appropriate means of communication, to ensure a mutually beneficial health care outcome. Interestingly, evidence emerged from the study that nurses perceived themselves as having less rights to access formal interpreters, compared with other multidisciplinary team members, such as social workers or doctors. However, this was not official local HSE policy but an unofficial practice that had evolved within the service over years. In effect, nurses felt excluded from using interpreters. Consequently, it appears that they may have felt powerless or disempowered to engage officially in securing a service for their use – but why was this, the case? Nonetheless, it is concerning that very few efforts were made by nurses to overturn this practice or indeed to seek clarification or insist through management, on access to interpreters when needed.

This understanding and perception by nurses can become a re-enforcing cycle and a self-fulfilling prophecy, resulting in inertia or maintenance of the status-quo, with limited opportunities for the development of cultural competence at individual or

service level (Kai et al 2007, Gabriel 2010). Although nurses rarely consider the business model approach to care, there is merit in communicating inventive and cost effective methods back to health care managers. This is especially significant where there is misinformation about the financial costs of employing interpreters and ignorance of the practical, social and healthcare value of ensuring an effective cross-cultural healthcare outcome (Mac Farlane 2009).

Correspondingly, the quantitative data indicated an evasive understanding around cultural sensitivity and contributed to the mixed and sometimes contradictory accounts. For example, 75% of nurses surveyed agreed that people from some ethnic groups can be very demanding. It is unsurprising therefore, that this finding may help to explain why nurses experienced difficulty in forming therapeutic relationships at times. However, it also raises questions, considered previously, about how nurses may be constructing and sustaining an inadvertent type of ethnocentrism within the Liffeside service.

Yet the qualitative data revealed some personal and informal efforts made by nurses to communicate with people. Nurses relied on their own resourcefulness, building upon their existing interpersonal skills. Interestingly, when describing successful and effective means of communication and the subsequent relationships they had established with clients, nurses appeared to be modest and undervalued their efforts in this regard claiming, *'sure it's just what we do'* or *'it's the basics you learn as a nurse'*. Although nurses were confident about their general communication skills in a shared common language healthcare environment (English speaking service users), the modesty and undervaluing of their skills and abilities within the cross-cultural and second language context could be interpreted as a lack of confidence.

Understandably, nurses were keen to portray themselves as offering culturally appropriate care albeit within a context of a poverty of data, preparation, knowledge and resources. In general, nurses in these situations felt helpless and under resourced, as at times they could not communicate due to language barriers and offer the level of support they would have liked. These experiences further compounded feelings of low confidence and of being unprepared and unskilled at times.

The implications for nurses of playing down their existing interpersonal skills may have resulted in a further disempowerment, felt by them in the context of establishing transcultural approaches. Nurses in the study tended not to refer back to nursing management for support. Where a minority did seek direction, they felt that nursing management themselves were not fully informed or resourced to respond effectively to their requests. Examples of community nurses' good transcultural communication practices were not formally fed back to health care management or the nursing service and therefore, very often, went unnoticed. Consequently, opportunities for appraisal and recognition that could have built on experiential learning within the service and amongst colleagues were lost.

In general, when exploring language and communication, the data has revealed that the majority of nurses were content with just getting by. This finding gives rise to further questions as to why nurses are prepared to be unreflective; why they apply the minimum standard when working with ethnic minority clients and whether they have considered the implications of this approach. Addressing the complexity of intercultural communication in an informed sustainable way does not appear to be evident from the community nurses experiences in this study. In the main, the system for enabling and supporting effective intercultural communication appears to be ad-hoc in nature. It is evident that a culture of ambiguity and a reluctance to establish effective, streamlined and regulated cross-cultural communication systems exists within the community health service in Liffeside.

However, the types of contrasting findings and experiences portrayed in this study revealed a nursing service that had struggled yet maintained a local sustained response, albeit very limited, to meet practical daily needs on the ground. Consideration ought to be given to the fact that nurses may not be intentionally creating barriers to establishing effective health care communication but are continuing to work in ways that they have been socialised into and that are now established as normal behaviour (Papadopoulos 2006, Kai 2007). Challenging such practices requires sensitivity and careful planning, within the knowledge base of transcultural health care and local demographics and service needs.

Although the findings are varied and ambiguous at times they illustrate a disconnection between the theoretical, professional intentions of nurses and the reality

of their practice and attitudes. Why do nurses feel it is acceptable to 'just get by' with minimal communication when working with ethnic minority people; when the same standards do not seem to apply within the context of shared language service provision to the indigenous English speaking population?

What remains unclear at this point is how these attitudes were formed and what factors contributed to their development? While this study is unique to community nursing in the HSE and the findings are new and important to the local context, they also correspond with the observations and interpretations by other commentators that there remains a dearth of published empirical nursing and healthcare research on cross-cultural communication in the Irish health care context (Lyons et al 2008, NCCRI 2008, Mac Farlane et al 2009). However, the evidence in this study also suggests a lack of awareness by nurses of a significant body of knowledge on this topic that exists elsewhere and a lack of desire locally to acquire such information and engage with it. While the scope of this study did not allow for investigation of service users experiences of communicating with the nursing service, the limited findings point towards implications for nurses and the need for further research.

Furthermore, some limited explanation may also be offered, in that there remains a gap at national level within the HSE organisation where no official Statutory in-house regulated system of formal health care interpretation or translation exists. In addition, there is no dedicated graduate course for the training of official healthcare interpreters in Ireland. Therefore, the current unregulated ad-hoc system continues to be a cause of concern for service users and for professional healthcare staff as practical, ethical and professional issues continue to arise (NCCRI 2008, Mac Farlane et al 2009).

Although nurses reveal themselves to be caring and sensitive, it is concerning that the evidence also reveals nurses think it safe to simply get by with minimal efforts. Nurses must not be complicit in any way in delivering sub-standard health care and need to be resourced and empowered to speak up and implement change in working with ethnic minority clients. Conversely, it is also worrying that the data revealed only limited capacity and inventiveness to overcome communication barriers. To build relationships that are professional and effective in public health requires clear and unambiguous communication. There is significant room for improvement in

Liffeyside in addressing these issues and some recommendations in this regard will be considered in the following chapter.

Theme Five: Professional Preparation and Support

The CCAT was limited in offering any in-depth exploration of nurses' feelings about working with ethnic minority clients in Liffeyside. However, the qualitative interviews offered a unique opportunity and in many ways, a privileged position for me, to engage with nurses in the area and to journey with them as they go about and understand their work. Some reflections in this aspect will be considered later in this section.

By and large, nurses confirmed their main source of acquiring transcultural information and knowledge was by learning on the job. They described that in the course of their work, they had learned primarily from ethnic minority clients themselves. Nurses demonstrated an understanding of the value of working together with clients as partners in care. For the most part, this was an experience valued by the majority of nurses and they were grateful for the opportunities to learn. Indeed, this is not unique to this nursing context or to health care (Benner 1984, Eraut 2004, NMPDU 2006). Even so, this finding is new for public health nursing in the HSE and will be important in determining how to progress cultural competence development in Liffeyside.

For the most part, learning on the job has occurred out of necessity and on reflection, nurses felt they had no option but to proceed and deal with situations head-on as they were confronted with issues in their daily work.

There were some nurses who were frustrated at not having had more formal preparation for dealing with ethnic minority clients and this appeared to impact on their motivation and confidence. There is also evidence of a lack of awareness by nurses of what transcultural nursing and cultural competence in healthcare mean. Therefore, it is unclear what type of preparation they may have wanted or expected. Furthermore, nurses tended not to seek assistance from nursing management and this

raises questions about their motivations, as they continued to work hard but were prepared to go it alone.

Considering the unprecedented and rapid growth of the ethnic minority population in Liffeside, it was not unusual for nurses to have felt this way. As the demographic situation unfolded, it required an immediate response by local services and therefore public health nurses did not seem to have the opportunities, in advance, to avail of specific preparation on cultural competence nursing. It is fair to say that nurses, health services management and nursing management were all positioned equally on a steep learning curve at the time.

However, the evidence both quantitative and qualitative, reveals that nurses were aware of a deficit in their knowledge and this understandably influenced their approach to caring for clients. For example, the CCAT survey revealed that when nurses were asked how informed they were of the cultural and social situation of their clients, 58% of nurses scored themselves at 6 points or less on the self-assigned VAS scores on cultural knowledge. The qualitative data supports this but also demonstrates inconsistency. However, what is interesting from the findings in this study when compared to similar studies elsewhere (Kai et al 2007) is that, in the main, participants in this study did not seek assistance or support formally through official channels. The findings provide evidence that nurses carried on regardless with limited reflection or concern about their knowledge deficits. It is a source of concern that nurses felt they should be provided with such information by management rather than actively seek it out themselves. Some of the possible reasons for this will be considered later.

Although the qualitative data revealed that nurses were continually acquiring transcultural knowledge and some skills in their work place, they seemed to place limited value on this type of learning experience and knowledge. Furthermore, the evidence suggests that nurses' perceptions of their newly acquired cultural knowledge led to a deficit in confidence. It is possible that, in turn, this led to feelings of disempowerment and a lack of motivation to change their circumstance.

However, it is also possible that nurses were continuing to do enough to get by and no more as a protective mechanism. They may have considered that acquiring further

skills and knowledge could have meant more work and responsibility, especially at a time when they already perceived working with ethnic minority clients as demanding and time consuming. However, it is important to note that despite these trends, nurses continued to demonstrate from experiential learning, a synthesis of personal and professional development and attempted to apply this learning in their practice, albeit in an ad-hoc and almost passive way (Hannabuss 2000).

Although the CCAT profile of this study reflected a favourable skill mix for the delivery of a modern community nursing service in Liffeyside, when combined with the qualitative data, the evidence revealed deficits in the transcultural preparation of nurses. Consequently, this affects the capacity of the service to deliver appropriate care to ethnic minority clients.

The qualitative data revealed that none of the nurses interviewed had any formal education or training in cultural competence in healthcare. Similarly, nurses stated that the core curriculum of their courses, from undergraduate to post-graduate studies, did not include any theoretical transcultural nursing component (Nic Philbin 2010, ONMSD 2012). Based on my practical experience in the field of refugee health and my limited teaching experience, this finding was not unexpected. However, it does reveal a significant gap between policy and practice (HSE 2008) and more importantly reveals the somewhat unrealistic expectations of community nurses.

Nurses primarily felt, that due to the absence of formal training or education in transcultural health care, they were somehow deficient or lacking in skills to deal effectively with ethnic minority health issues. While this may be true to a limited degree, one interpretation of this outcome may be that nurses overstated the value of formal transcultural education and had unrealistic expectations of what this could impart to them.

Although this finding is unique to Liffeyside nurses and demonstrates a lack of formal transcultural education in the service and profession, the finding echoes other research commentators, who acknowledge a paucity of professional transcultural health care education across the disciplines in the Irish context (HSE / Thrive 2005, HSE 2008, Touhey 2009, Donohue 2010). Furthermore, the evidence suggests that knowledge to empower nurses cannot be confined solely to the acquisition of

theoretical and professional cultural competence education but should contain an evaluation and reflection process on their experiential learning (Benner 2004, Eraut 2004, Traynor 2010).

While scientific and theoretical knowledge is essential for the development of culturally competent services and staff, collaborative partnership models with ethnic minority community members can also be beneficial. For example, a minority of nurses mentioned 'in-service' type work-shops or study days they had attended, facilitated mostly by non-governmental agencies or immigrant-led community-based organisations. Participation by nurses at such events can serve a local need, such as awareness raising and information gathering, at individual and service level.

On the other hand, nurses mentioned that these events tended to be short, one-off opportunities and although the content of such events was helpful, they felt information was too generic and not specific to health. Although the provision of such initiatives is well intentioned and has many benefits, difficulties may also arise where these methods are viewed and experienced by professionals as the only or most convenient way of acquiring transcultural information. Consequently, it may serve as an easy option for nurses and deter them from engaging with evidence based literature or in-depth empirical explorations, such as undertaking transcultural nursing research.

Nonetheless, community development approaches have clear benefits for staff and services and more importantly for the health and wellbeing of communities. Active participation by community nurses in such initiatives affords opportunities to influence the planning, design and implementation of culturally competent care. It will enable a wider understanding and experience of learning about cultural competence in primary health care (Jefferys 2005, Baisch 2009). Indeed, this approach is not unfamiliar to public health nurses, who already apply many health promotion and collaborative working methods on other types of primary care projects with marginalised groups, such as Traveller Health and Mental Health (DoHC 2001, Clarke 2004, Pavee Point 2009).

Overall, despite evidence of nurses working diligently, the evidence suggests a lack of vision and commitment from nurses and their managers, in implementing professional preparation for working with culturally diverse populations. It calls into question the

professional and socio-political thinking that inform approaches to culturally competent care within organisations and more specifically, the nursing profession (Gustafson 2005, Culley 2006). Any approach to primary care cultural competence work requires significant investment and commitment from a personal development perspective and can be both sensitive and challenging. While engagement of this kind by nurses is to be welcomed, it also requires considerable sensitivity (Markey et al 2012). It is a cause for concern that the data does not reflect a supportive environment that encourages nurses to develop leadership capacity and skills that could provide a lead on care planning and service provision in developing cultural competence.

The qualitative data demonstrated that nurses had only limited opportunities for meeting and supporting each other. Yet it also revealed that the main type of support nurses availed of was work-based relationships, established between each other as colleagues. However, these were infrequent and primarily consisted of impromptu encounters where opportunities for conversations or discussions about transcultural issues may arise. In the course of these informal encounters, nurses exchanged information, ideas, guidance and direction, based on each other's positive and negative experiences. They informally discussed what worked well or did not work well for them. On reflection, for the majority of nurses, this sharing of information was a significant means of finding solutions to transcultural challenges and problems they encountered at times. Interestingly, participants tended to play-down these support mechanisms and therefore had an under-appreciation of their value.

Understandably, as these encounters were considered informal and perhaps more personal in nature, nurses did not describe the types of issues or language they used in these exchanges in any significant detail. While valuable to a degree and reasonably well intentioned, this type of support can have risks and could negatively impact on the delivery of ethical and professional transcultural care (Gallagher 2006).

In the main, the evidence suggests that these informal types of support did not provide opportunities to professionally challenge each other or critique approaches to working with culturally diverse clients. There is a danger that this could result in re-enforcing personalised and professional ethnocentrism or stereotyping within the service or at worst, perpetuate inadvertent racism amongst nurses. However, it must be acknowledged that nurses valued the limited support they provided to each other.

It is understandable that there are psychological, social, and professional factors that may influence organisational and individual responses to difficult emotional work-related issues (Smith 1992, Menzies 1960, Gabriel 2010). This, coupled with a lack of cultural competence and transcultural nursing knowledge, can sometimes manifest as ignorance, self-preservation or disinterest in the attitudes and behaviours of staff. Although not ideal, the evidence suggests that nurses in Liffeside have identified a gap in support on transcultural issues and what is required is some structure of supervision and education to empower them in their cultural competence development.

Community nurses had a pragmatic understanding of the level of support they could receive from their line managers on transcultural issues. A positive aspect was that nurses felt they could approach their nursing managers for support but the evidence suggests they rarely if ever did so. Interestingly, community nurses perceived nursing management to be on a parallel learning curve with little or no additional information or resources available to them. Therefore, community nurses were reluctant to seek additional support from nursing management. While this may be interpreted as community nurses being empathic towards nursing management, it may also reflect a *laissez-faire* approach and a lack of will or motivation to implement change. Furthermore, it may demonstrate a lack of interest in working collaboratively with their managers or a lack of trust in the ability to admit deficits in competence. It may also reflect the reality that community nurses are predominantly sole-practitioners with high-skills and possess the ability to be resourceful and inventive and are able to problem solve quickly.

If nursing management is not made aware of specific transcultural challenges and issues by nurses, development of culturally competent services will not be possible. As this study focused on nurses in practice, the scope of this project did not allow for any investigation of community nursing management structures or the collective cultural competence of the nursing management department. Therefore, in the context of findings from this study, further research within the public health nursing management structures of the HSE organisation locally and nationally, would be valuable and should be considered at a future date.

An obvious disconnection between the majority of nurses and the HSE corporate managerial system was evident. The qualitative data revealed that the majority of community nurses feel their voices and experiences do not influence decisions made by senior general managers within the HSE organisation in Liffeside. During the interviews, participants mentioned they had little or no interaction with HSE general management. As seen previously, nurses generally do not envision themselves as leaders in healthcare organisational contexts (Carney 2009).

Even so, this study has revealed practical qualities in nurses that emerged from transcultural situations in their work place. What is significant and also concerning, is that nurses do not appear to value these experiences or consider their leadership potential in developing cultural competence in Liffeside. The evidence in this study points to a clear need for support from HSE management.

The analysis of the qualitative data and subsequent emergence of the key theme of professional preparation and support, had a particular resonance for me. As a nurse who had commenced in community care and developed my own career pathway in migrant health, I was conscious of the element of vulnerability and risk that participating in the study may reveal for the nurses, especially around such a sensitive topic. I could empathise with their situation and being honest, I was nervous and possibly fearful. I was aware of the vulnerabilities and risks that I had experienced in getting to this point as a CNS, especially those times when I found I was deficient. I did not want this to colour my engagement with the process but at times it was not possible to detach myself from this subjectivity. Likewise, I also kept in mind that the descriptions of nurses' experiences may have included an element of positive research bias. Nonetheless, the experiences described by the nurses replicated my own experiences at some point in time. In developing my own leadership abilities, I am conscious that one becomes transformed from knowledgeable doer, by a more informed understanding of oneself, reaching what Adair (2002) refers to as 'phronesis' - a blend of intelligence and experience, serviced by character. While transformation takes time, it also requires commitment, motivation and perseverance at individual and organisational level. My concern is, that although the HSE has to take responsibility for preparing staff, post-graduate nurses must also be accountable for their own development.

The following chapter will conclude with a summary of the study and will also address some recommendations based on the evidence to emerge from my original research questions.

Chapter Seven: Conclusions & Recommendations

Conclusions

The overall context for this study has been the unprecedented and rapid growth in population and cultural diversity in Liffeside, Dublin and the subsequent experiences of community nurses in response to this change.

In responding to the rapid change, nurses continued to provide a service in the area, thinking on their feet and learning as they went about their work. However, there was evidence of very limited reflection by nurses and, by and large, this manifested in an unconscious, ethnocentric attitude that negatively influenced their practice and cultural competence development.

Although keen to establish therapeutic relationships, nurses demonstrated limited levels of cultural sensitivity, creating barriers and preventing them from engaging with clients in any meaningful, culturally competent way. Many of these barriers were self-imposed while others were structural and organisational. Consequently, nurses encountered difficulty progressing to the more advanced level of culturally competent practice. Nurses continued to function at the lower level of cultural awareness, as determined by their CCAT scores, and tended to carry on in the ways in which they had been socialised, reluctant to change or develop their cultural competence. Even though the evidence suggests that nurses felt disempowered in decision making, in the main, they were content to just get by. Perhaps this was for self-preservation or a means of protection for nurses who felt overburdened and unsupported. Or perhaps they simply did not want to, or felt ill prepared to deal with, supporting marginalised clients affected by wider socio-cultural issues

Although nurses admit to having very little knowledge, preparation and support the data provided evidence of minimal efforts by nurses to seek assistance. The study identified a gap in the provision of professional transcultural preparation and support available to nurses. It raises doubts about the current lack of systems in place to counteract this deficit in the workplace and the weaknesses in the formal professional education that nurses, and in particular graduate public health nurses, receive relating to cultural competence and transcultural nursing.

Evidence of a lack of knowledge and motivation to seek communication support for non-English speaking clients, demonstrates an incongruity within nurses' experiences. It is of great concern that nurses appear to require some convincing that clear unambiguous communication is a fundamental component of basic clinical care and they remain unaware of the possible implications for their practice and clients. Examples of this are evident where none of the nurses had engaged, or attempted to engage, the services of a formal interpreter for clients. On one level, nurses admit they lack confidence and knowledge in their capacity to provide culturally appropriate care, while on the other, they continue to work in ways that are unreflective and limited, appearing content to get by.

Ambiguity and tension existed for nurses in how they constructed or understood fundamental concepts such as culture and ethnicity. They portray a genuine ignorance about their own cultural self-awareness and how this may influence interactions with ethnic minority clients. Indeed, in discussing cultural diversity issues, nurses demonstrated an uneasiness and ignorance around the appropriate use of terminology. This was demonstrated by the failure to challenge or critique stereotyping or discriminatory practices experienced by nurses and / or clients in the service. Furthermore, when working with ethnic minority clients, nurses tended to focus on difference rather than what they and their clients had in common. In the main, this resulted in an "othering" and "problematizing" of clients, rather than nurses reflecting on the limitations and inappropriateness of the service or indeed on their own efforts to meet the specific needs of minority clients.

Of particular significance was the reluctance by community nurses to explicitly name and acknowledge the existence of racism, whatever its nature (unconscious, conscious, direct or indirect), amongst themselves and their service. Although this finding corresponds with other studies elsewhere, it reinforces a false illusion that racism does not exist in community nursing in Liffeside. Combating racism and discrimination is a fundamental component of cultural competence and transcultural nursing. Although there was no evidence of blatant or overt direct racism, nurses appeared to have limited understanding or awareness of the concept of institutional racism and how their ethnocentrism could be complicit in it.

In the main, this study provided nurses with an opportunity to think and reflect for the first time, on the concept of transcultural nursing and cultural competence in Liffeside. The following section will outline some recommendations relevant to the findings of this local study.

Recommendations

My study has revealed a number of core challenges to the delivery of culturally competent nursing practice in Liffeside. Fundamentally, the data from the nurses describes a mostly inadvertent ethnocentric attitude that results in the perpetuation of institutional racism in the service. This is related to a number of barriers, some self-imposed and others structural and organisational, that impede nurses' practice with ethnic minority clients. Furthermore, these challenges are underpinned by a lack of knowledge, motivation and a sense of disempowerment among nurses.

The study generated a significant amount of evidence and it is not possible to consider recommendations for the totality of findings. Therefore, I propose recommendations to address the most important and fundamental gaps and barriers, restricting the development of culturally competent practice by nurses in Liffeside.

In order to address these challenges, I would recommend a three pillar approach to the development of culturally competent practice with ethnic minority service users in Liffeside. This approach will address the main areas that emerged from the evidence and that require improvement and change. These will involve personal, professional and organisational investment and are as follows:

1. Education and Training
2. Supervision and Mentoring
3. Policies and Procedures.

Due to the complexity and multifaceted nature of cultural competence development, there will be a natural level of interconnectedness between the three pillars. This will allow for a whole organisation approach that takes account of the type of work and professional environment that nurses in Liffeside work in. Therefore, these recommendations involve a developmental, educational process of deeper and

reflective engagement and also a limited structural component, relevant to the organisation and service in Liffeside.

Education and Training

The first pillar would be the introduction of an education and training programme, focused on personal and professional development. The programme would specifically introduce nurses to the concept of cultural competence in health care and be inclusive of an anti-racism component. It is recommended this programme become part of the core Continuing Professional Development education schedule in Liffeside nursing service.

The programme would draw on the principles and theories that underpin culturally competent health care and that complement nursing and healthcare practice, such as human rights, ethical care, equality, socio-political systems and intercultural relations. Acknowledging that cultural competence is a life long process, the programme would focus on human and professional development aspects of care.

The programme could be largely, but not exclusively, based on the Papadopoulos Tilki Taylor Model for Developing Transcultural Nursing Competence, where nurses through facilitated reflection, can harness their experiential learning and acquire new knowledge and skills, enabling them to move from generic to specific cultural competence.

It will require a staged and phased implementation over a period of time and need to be provided in a safe and sensitively managed learning environment. Given the sensitivity of issues such as ethnocentricity, racism, gender roles, family size, and childrearing practices, the training must be facilitated by experienced teachers. While a safe, confidential atmosphere is important, transformational learning inevitably involves discomfort which must be handled carefully and non-judgementally.

Ideally, this training would be mandatory and undertaken over a period of time, to allow for preparation, reflection and to encourage the use of real, live case material and the involvement of community representatives and other professionals.

The programme would be delivered using mixed education methods, including experiential, participatory and theoretical content to explore and consider examples of good practice. Participants will be afforded opportunities to avail of resources and learning materials. The total duration of the programme, including evaluation, will vary on need and can be planned accordingly with the Director of Public Health Nursing and the Assistant Director responsible for Continuing Professional Development in Liffeside nursing service. An example of this type of training programme may consist of the following:

Cultural Competence Training Programme (2 day-Template)

Liffeside Public Health Nursing Service

- 4 hours** ***Introduction to Cultural Awareness:*** This stage will involve participants exploring their own understandings of cultural identity, cultural values, ethnocentrism, commonalities and differences, and how they affect the delivery of care and development of relationships.
- 4 hours** ***Cultural Knowledge:*** Exploring culturally defined health beliefs, behaviours & systems of care, healthcare anthropology. Barriers at a personal, professional, organisational and societal level. Political influences (power dynamics) in the health care context.
- 4 hours** ***Cultural Sensitivity:*** Exploring interpersonal and communication factors for the development of therapeutic relationships (empathy, trust, respect) in the intercultural context and negotiating barriers to accessing health care.
- 4 hours** ***Cultural Competence:*** Exploring ways of providing culturally competent care, including culturally appropriate skills in clinical assessment. Exploring skills and knowledge required to address and challenge racism and other forms of discrimination in the health care context.

A core component of the training programme would be evaluation and actions / outcomes anticipated and expected from the programme. Consequently, the support and availability of facilitators / trainers and nursing management to nurses, in a professional and confidential context and to assist in bridging the gap between education and training and preparation and support, is essential. Participants must be supported through the process by each other and by managers or mentors, who can encourage, motivate and guide them.

Supervision and Workplace Mentoring:

This second pillar is the provision of supervision and workplace mentoring for nurses. The evidence demonstrated lack of confidence, poor motivation and disempowerment, including unreflective practices by nurses when working with ethnic minority clients. Although the training and educational component will assist in skill and knowledge acquisition, including opportunities for reflection, the opportunity of a specific supervision and workplace mentoring programme will strengthen and further support the development of culturally competent practice in Liffeside. The aim is to facilitate exploration of nursing practice and the development of interpersonal relationships with different clients. The hope is to encourage greater interaction with clients, openly learning from them and from other colleagues, in a safe and trusting environment.

While nurses may rightly fear making a mistake, they must be assured that if they occasionally get things wrong for the right reasons, they will be supported, provided they learn from their error.

A key part of the supervision will be to encourage nurses to become more assertive, in order to challenge their colleagues, managers and organisation to address poor practice and the failure to provide appropriate resources or to take action against all types of discrimination. In this context, nursing and HSE management need to show leadership and demonstrate their own willingness to learn, understand and develop a culturally competent local health service. Therefore, management should give a commitment to undertake the appropriate level of cultural competence training.

It is recommended that the nursing manager with responsibility for continuing professional development (Assistant Director of Public Health Nursing), in collaboration with the professional development committee for the area and an expert in the field e.g. Clinical Nurse Specialist (Asylum Seekers Health Assessment), develop and put in place a specific programme of supervision and workplace mentoring for nurses in Liffeside.

The provision of supervision and mentoring specific to cultural competence, could be implemented on a phased basis, in conjunction with the cultural competence training. For example, as a requirement, nurses who undertake the cultural competence training and education programme are provided with workplace supervisory support for a determined period of time. The officially approved methods and regulatory standards for supervision and mentoring in continuing professional development for nurses in the workplace would apply. It is recommended that this supervision and mentoring support be included as a core component of nurses' on-going regular supervision in Liffeside. The supervision and mentoring should only be provided and facilitated by an experienced and qualified nursing educator / practitioner, with experience of supervision and ideally experience in transcultural healthcare.

Policies and Procedures

The recommendations from the previous two pillars have specifically addressed the more practical and interpersonal aspects of cultural competence development. This third pillar of the approach is about structural and organisational gaps and barriers, identified in the study. For example, the availability of a specific policy and procedure, such as practice guidelines, to assist with cultural competence development for nurses in the Liffeside area.

While limited in their value if applied and referred to without any professional education or facilitation; practice guidelines can provide some useful information to assist with practice in the workplace.

Therefore, it is recommended that a specific set of practice guidelines for cultural competence development be developed and made available to assist nurses in Liffeside (**see appendix E for sample of Practice Guidelines**). Development of the guidelines should be informed by best practice and scientific evidence from transcultural health and social care. These practice guidelines should be developed in conjunction with local nursing management, the continuing professional development committee in HSE Liffeside and an expert in the area of transcultural nursing / healthcare. In keeping with good clinical governance, they should meet the required regulatory standards of the nursing board and the local HSE nursing practice unit, for professional practice guidelines in the workplace.

In keeping with the interconnectedness of the 3 pillar approach, it is recommended that reference to, and learning opportunities for, discussion and reflection on the practice guidelines be included in the education and training and supervision and mentoring components of the approach.

There are clearly matters that the Irish government, the HSE, the Irish Nursing and Midwifery Board must address in relation to the fair and just treatment of people who are refugees, asylum seekers or migrants. These include barriers to accessing services, enforced poverty and unemployment, lack of linguistic supports, all of which can negatively impact on people's health and wellbeing. The absence or weakness of wider policy and legislation has the capacity to impact on how well the providers and staff of Liffeside caters to the needs of their clients. However, the scope of this study does not allow for these to be addressed.

However, this study has identified a need to improve the transmission of information from national HSE policy to practitioners at grass roots level, in the context of culturally competent health care. In light of the findings of this study, I will be recommending that the HSE undertake a review of the National Intercultural Health Strategy 2007-2012. I have already confirmed my commitment and willingness to co-operate with future research in this area with the HSE Social Inclusion Unit and specifically, in community nursing.

It is important that nurses in Liffeside understand the association between their professional role and other wider responsibilities. In undertaking practical approaches, nurses must be reminded of their moral, legal and professional obligations to take active steps towards combating racism and other forms of discrimination in their practice, as per the Code of Professional Conduct and Ethics for Nurses (An Bórd Altranais 2000) and the broader legislative obligations that govern public service provision (National equality and anti-discrimination laws as outlined in Equality Legislation 1998-2011).

Of particular interest to me as a nurse practitioner, is the transferability of this knowledge to other areas and disciplines in the local primary healthcare context in

Liffeyside. Dissemination of the findings from this study will also be relevant to other disciplines and services. Consequently, I intend to use and publish variations of the data from this study in nursing and multidisciplinary professional journals e.g., community development, adult education, equality studies.

At times, my experiences of learning, researching and reflecting were confusing and disconcerting, exposing my vulnerabilities and weaknesses. However, there were also enlightening and memorable learning opportunities that provided personal and professional growth, resulting in some transformational change. Just as leadership need not be a lonely place as alluded to by some writers, neither must the transcultural nursing experience. By acquiring knowledge, seeking out relationships, building teams, developing trust and acknowledging that leaders are also followers, community nurses and health services in Liffeyside can become more culturally competent to meet the needs of the whole community.

Appendices

Appendix A – Ethical Approval Letter



**Middlesex
University**

School of Health and
Social Sciences
The Archway Campus
Furnival Building
10 Highgate Hill
London N19 5LW

To: Patrick J Boyle
Doctorate in Professional Studies (Health)

Date: 21st July 2008

Dear Patrick

Re: Patrick J Boyle (519) *"An Assessment of Cultural Competence in the HSE Local Health Office North West Dublin Primary Care Nursing Service"* Category A2 – Supervisor: Mary Tilki

Thank you for the response which adequately answers the ethics committee's queries. On behalf of the committee, I am pleased to give your project its final approval. Please note that the committee must be informed if any changes in the protocol need to be made at any stage.

I wish you all the very best with your project. The committee will be delighted to receive a copy of the final report.

Yours Sincerely

Dr John H Foster
Chair of the Health Studies- Sub-Ethics Committee

Appendix B – Participant Information Sheet

Official HSE Headed Department Paper

HSE LOGO Here

Date:

Dear Participant,

My name is P.J. Boyle and I work as a Clinical Nurse Specialist (Asylum Seekers' Health) in community nursing services of the Health Service Executive (HSE) Local Health Office, Dublin. I am currently undertaking a research project that aims to evaluate the levels of cultural competence in primary care community nursing services in the Liffeside health service area locality.

The title of my research project is: **“An Assessment of Cultural Competence of the Community Public Health Nursing Service in Liffeside Health Area Dublin”**.

Before you decide to take part it is important you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please feel free to contact me if you are not clear or if you would like more information.

Yours Sincerely,

Patrick J. Boyle
Clinical Nurse Specialist
(Asylum Seeker's Health)

(Official HSE Letterhead)

Participant Information Sheet
(Community/Public Health Nurses)
RE: Cultural Competence Assessment Tool Community Public
Health Nursing

Study Title:

“An Assessment of Cultural Competence of community public health Nursing in Liffeside health service area Dublin”

Background and aim of the research:

Results from the 2006 Irish census estimate the number of non-Irish nationals in the country to be greater than 10% of the total population. It further acknowledges that some areas of Ireland are more culturally and ethnically diverse than others. Liffeside health service area falls into this category, with some estimates recording 20%- 25% ethnic diversity (CSO 2007, HSE Population Health 2007). Consequently, there is a need to deliver healthcare services to an increasingly diverse population.

There is growing evidence from other countries that cultural diversity directly influences health outcomes and that factors such as accessibility, availability and the competence of health workers are significant. As no specific cultural competence primary care nursing studies have been conducted in Ireland to date, an evaluation in the context of changing demographics and service delivery is timely.

Internationally the nursing profession has a proven track record in researching and evidenced based practice in culturally competent healthcare. Therefore, in keeping with the recently launched National Intercultural Health Strategy 2007- 2012 (February 2008), this study aims to provide empirical evidence which will inform the transformation of HSE Primary Community and Continuing Care and HSE Social Inclusion.

Why you have been chosen ? An Invitation to Participate:

The target population for this study are all nurses and nursing service managers working within Liffeside Community Public Health Nursing Services. You have been invited to take part in this research because you are one of the 35 nurses working within in the Liffeside health service area locality.

What does taking part involve ?

Your participation in this research project is entirely voluntary. If you decide to take part you will be given this information sheet to keep and may be asked to sign a consent form for interview. Your participation will involve two stages in the study i.e.

1. Completion of a self-assessment exercise (Cultural Competence Assessment Tool)
2. Individual in-depth interview (consent required).

1. Cultural Competence Assessment Tool

The Cultural Competence Assessment Tool for Community Public Health Nurses was devised at the Research Centre for Transcultural Studies in Health at Middlesex University and is suitable for use in the Irish primary care nursing context. The CCA Tool is being used with kind permission by Professor Rena Papadopoulos.

Your participation will involve you filling out the Cultural Competence Assessment tool (CCA Tool). This is an anonymised, self-assessment tool. An instruction sheet with guidelines on how to complete the assessment will accompany the questionnaire. You will receive this by internal HSE post to your work location. It should be completed and returned to the researcher by the specified date in the addressed envelope provided.

2. Interviews

A separate interview consent form will be sent to a purposive sample of 10-12 nurses specifically identified by the researcher because they are working in primary care settings. They will be chosen because they work with or potentially work with refugee/ asylum seeking/ ethnic minority clients and have knowledge of issues faced by them. Interview participation is voluntary. The consent form should be completed and returned according to the instructions. Participants will be contacted to arrange a mutually convenient date, time and venue for interview. Interviews will last one hour. The purpose of the interviews will be to clarify and elicit further data and issues emerging from the cultural

competence assessment tool (CCA Tool). The interview will provide you with an opportunity to seek further clarification and make additional comments / observations.

Is taking part in this study confidential?

The questionnaire and interviews will be confidential as CCA Tools and interview transcripts will be anonymised by the use of a code, the key to which only the researcher will have access. The code will be stored on the researcher's personal computer in a password protected file. Although the cultural competence of each team member will be assessed, only the overall score of the team will be identified. Individual scores will not be revealed.

Interviews will be recorded with your permission and transcribed by me. The data gathered is for the purpose of this study only. As I am the sole researcher, I will be the only person with access to the data, apart from my academic supervisors, who may need to verify findings. All recordings and transcriptions will be protected and kept securely in keeping with the Data Protection guidelines (Data Protection Act 1988/2003). Transcription tapes will be deleted on completion of the study.

Throughout the research process the confidential relationship will be maintained. Reporting data and/ or citing informant quotes will be anonymised in a way which is not attributable to a particular individual removing or encoding identifying details as necessary.

What is the duration of your involvement in this project?

The overall duration of this research project will be six months. However, the duration of your involvement in this project will simply include your time filling out the CCATool (approx. 30 mins) and the one hour interview if selected. Your time is greatly appreciated.

What will happen to the results of the research study?

A final report of the findings will be published and will form my thesis for the award of a DProf (Transcultural Healthcare). The report will underpin on-going development/implementation of the HSE National Intercultural Health Strategy and the Primary Community and Continuing Care Transformation project. This report will be widely circulated with the HSE Dublin Local Health Office (multidisciplinary) and copies of the summary will be made available to all participants involved in the research. Aspects of the research may be published in peer review

journals. Consequently, it is intended that this research will have a local and national impact.

Who has reviewed & approved the study?

This research study forms part of an accredited professional academic & work based learning programme at Middlesex University School of Health & Social Sciences. Approval has been sought from The Health Studies Ethics Sub-Committee at Middlesex University. Within the Health Service Executive (HSE) approval has been granted by the Director of Public Health Nursing (HSE Dublin LHO Area), the Manager for Social Inclusion (HSE Dublin LHO Area) and the HSE Assistant National Director for Social Inclusion.

Contact for further information:

If you require further information or clarification, please do not hesitate to contact me or my research advisor at the following contact details:

P.J. Boyle
Balseskin Health Centre
Balseskin Refugee Accommodation Centre,
St. Margaret's Road,
Finglas
Dublin 11.
Tel No: 01-8569015 / 01- 8569080 (Direct line)
Mobile No: 087-9120382 (Work Based Mobile)
Email: pj.boyle@hse.ie

Academic Advisor

Dr Mary Tilki
Principal Lecturer
School of Health and Social Sciences
Middlesex University
Hendon Campus,
The Borroughs
Hendon
London NW4 4BT
Tel No: 0044208 411 5150 (Direct line)
Email: m.tilki@mdx.ac.uk

Thank You for taking the time to participate in this research project

INTERVIEW CONSENT FORM
(Community Nurses)

Title of project:

“An Assessment of Cultural Competence of community public health Nursing in Liffeside health service area Dublin”

Researcher:

P.J. Boyle

CNS (Asylum Seekers' Health)

I confirm that I have read and understand the information sheet dated for the above study and I agree to the interview being recorded. I have had the opportunity to ask questions and clarify my participation in this research.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

I agree to take part in the above study.

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Note: Copy for Participant & Copy for Researcher.

Appendix C – Cultural Competence Assessment Tool



The RCTSH Cultural Competence Assessment Tool (Community Public Health Nurses Staff Specific)

Thank you for agreeing to complete this questionnaire. The data gathered from this will be used to help assess your cultural competence. The questionnaire is completely confidential and anonymous. Any reporting of data will be done in such a way that none can be assigned to a particular individual.

The questionnaire is a self-assessment exercise.

In the **tables** of statements please tick the response that seems most appropriate. Do not spend much time thinking about your answer. Please tick all the boxes. Leaving unticked boxes or responding 'not applicable' will negatively affect your total score.

Please use the **box** to elaborate on any of your responses, noting the statement number.

On the **lines** please circle the number that is nearest to where you feel you are regarding the statements.

Please return your completed assessment in the envelope provided in the
INTERNAL POST by: / ____ / ____

Thank you again for completing this questionnaire.

A) Assessing Cultural Awareness

	Statements	Strongly agree	Agree	Disagree	Strongly disagree
1	Cultural upbringing impacts on the way in which individuals view other people				
2	People from different ethnic groups share many of the same values and beliefs as people from the host community				
3	There are many differences in values and beliefs within any single ethnic group				
4	Gender, age, class and generation are as important as ethnicity in forming a person's identity				
5	Ethnic identity changes with time and the influence of wider social factors				
6	Some aspects of culture are more important to a person than others				
7	People select the most relevant aspects of their culture in different situations				
8	People from different ethnic groups may have the same needs but they may be expressed in different ways				
9	To avoid imposing values on a client practitioners should be aware of their own value and belief systems				
10	Ethnic identity is influenced by personal, social and psychological factors				
Please elaborate on any statement/s					

I am not at all aware
Of my own ethnic
and cultural identity

I am highly aware
of my own ethnic and
cultural identity

1 2 3 4 5 6 7 8 9 10

B) Assessing Cultural knowledge

	Statements	Strongly agree	Agree	Disagree	Strongly disagree
1	Monitoring the ethnicity of all clients can help identify the effectiveness of service access and delivery				
2	Effective care requires an adequate knowledge of the client's culture				
3	It is not possible to have full knowledge of all cultures				
4	There is much to be learned from the folk systems of the client				
5	People from minority ethnic groups have particular difficulty accessing community health services				
6	Discrimination and harassment in everyday life leads people to engage in behaviours which may be damaging to health				
7	Infant mortality rates are higher for minority ethnic groups than the National average				
8	High blood pressure is more common amongst Black people than the white population				
9	It is important to acknowledge particular cultural beliefs and practices in relation to delivering public health activities to minority ethnic groups				
10	Coronary heart disease is more common amongst People from South Asian communities than the white population				
Please elaborate on any statement/s					

I am not at all
informed about the culture
and social situation of
the majority of my clients

I am very well
informed about the culture
and social situation of
the majority of my clients

1 2 3 4 5 6 7 8 9 10

C) Assessing Cultural sensitivity

	Statements	Strongly agree	Agree	Disagree	Strongly disagree
1	It is almost impossible to communicate with a client whose first language is not English				
2	Greeting family members before the client may be appropriate in some minority ethnic groups				
3	Clients who avoid eye contact are always suspicious or withdrawn				
4	Practitioners need to be trained in the use of interpreters and advocates				
5	Interpreters and advocates need to be trained in order to effectively represent the best interests of the client				
6	People from some minority ethnic groups can be very demanding				
7	It is important to discuss the impact of ethnicity on the therapeutic relationship where the client and practitioner are from different cultures				
8	Religion can be a source of comfort and reassurance for some clients				
9	People from minority ethnic groups get little benefit from psychological therapies				
10	The stigma of unmarried teenage conceptions is greater in some minority ethnic groups than in the host community				
Please elaborate on any statement/s					

I am very uncomfortable working
whose beliefs, values
and practices are different from my own

I am very comfortable working with people
with people whose beliefs, values
and practices are different from my own

1 2 3 4 5 6 7 8 9 10

I am not at all confident of my ability to
establish trust, show respect and empathy
to all people whatever their culture

I am very confident of my ability to
establish trust, show respect and empathy
to all people whatever their culture

1 2 3 4 5 6 7 8 9 10

D) Assessing Cultural Practice

	Statements	Strongly agree	Agree	Disagree	Strongly disagree
1	Subtle forms of racism are as damaging as overt forms				
2	Institutional racism is seen in unwitting prejudice, ignorance and thoughtlessness				
3	Recognising and challenging institutional racism is the responsibility of each individual health practitioner				
4	User participation is a critical component of good practice and should be encouraged at all levels of service provision				
5	Professionals and clients need training in user participation				
6	Best practice can be achieved by joint partnership between statutory and voluntary sectors				
7	The expertise of the minority ethnic voluntary sector should be used more effectively to obtain advice on good practice				
8	Stereotypes have an impact on how clients are assessed				
9	Cultural assessment should be integrated into practitioners assessment and not done separately				
10	Public health initiatives should take into account cultural influences and their effect on the client, family and community				
Please elaborate on any statement/s					

I am not at all able to incorporate the clients cultural beliefs into the care and treatment I provide

I am very able to incorporate the clients cultural beliefs into the care and treatment I provide

1 2 3 4 5 6 7 8 9 10

I am not at all confident to challenge racism and discrimination towards clients, carers and staff

I am very confident to challenge racism and discrimination towards clients, carers and staff

1 2 3 4 5 6 7 8 9 10

Participant Profile: (Confidential)

Please complete the following questions. All questions must be answered. For each question please tick and /or state the answer(s) relevant to you.

1. Gender: Male () Female ()
2. Age: _____ (Yrs)
3. Country of Birth: _____
4. If born *outside* of Republic of Ireland (ROI) state how long you have lived in ROI to date? _____ (no. of years)
5. What is your first language? Please state: _____.
6. Do you speak another language fluently? Yes () / No ()
Please state other language _____.
7. What religion (if any) are you affiliated with? (please tick)

(a) Christian () (b) Muslim () (c) Jewish ()
(d) Buddhist () (e) Hindu () (f) Sikh ()
(g) Atheist () (h) Other (Please State): _____
(i) None ()
8. What is your Ethnic or Cultural background?

White: White Irish () Irish Traveller ()

Any other White background ()
Please State: _____

Black or Black Irish:

African () Any other Black background ()
Please State: _____

Asian or Asian Irish:

Chinese () Any other Asian background ()
Please State: _____

Other (including mixed background): ()

Please State: _____

(Continued overleaf)

WORK & Professional Profile:

9. What is your current nursing employment position:

- A) Community RGN ()
B) Public Health Nurse ()
C) Other (Please State) : _____

10. Please tick any additional nursing registrations relevant to you:

- A). RGN (General) () B). RCN (Children's) ()
C). RM (Midwifery) () D). RPHN (Public Health) ()
E). RNID (Intellectual Disability) ()
F). RPN (Psychiatry) () G). RTN (Tutor) ()

11. Are you currently registered as a nurse in any other country? Yes () / No ()

If yes please state what country: _____

12. Have you ever worked as a nurse outside of Ireland? Yes () / No ()

If yes please state where: _____

13. How long did you work as a nurse outside of Ireland :

1 – 3 yrs (), 3 – 6 yrs (), More than 6 yrs () Please state: _____ yrs

14. How long have you worked as a nurse in Ireland?

1 - 3 yrs (), 3 – 6 yrs (), More than 6 yrs () Please State _____ yrs

15. Please specify if you hold any of these nursing qualifications:

- A). Undergraduate Nursing Degree (BSc, BNS) Yes () No ()
B). Post Graduate Nursing Qualification: Yes () No ()
Please Indicate type
Higher Diploma ()
Masters Degree ()
PhD / Doctorate ()
Other ()
Please State: _____
None ()

16. How many years in total have you worked as a registered nurse? _____ (yrs)

17. How many years have you worked in your current location (site)? _____ (yrs)

THANK YOU

Many thanks for completing this survey questionnaire. Please return it to the researcher by the specified date in the addressed envelope provided. Your contribution in this survey remains anonymous and confidential and is for the purposes of this study only. The researcher gratefully acknowledges the permission given by Professor Rena Papadopoulos to use this Cultural Competence Assessment Tool.

Researcher Contact Details:

P.J. Boyle
Clinical Nurse Specialist
Balseskin Refugee Health Centre,
Balseskin Reception Centre
St. Margaret's Road,
Finglas
Dublin 11.

Tel: 01-8569015
Mobile: 087-9120382
Email: pj.boyle@hse.ie

Appendix D – Semi Structure Interview Guide

Background Information:

Please describe your nursing background.....

- Nursing role - / Nurse training / Education
- Number of years nursing experience - home and / or abroad
- Number of years working in Liffeside Health Area Dublin

With regard to cultural diversity.... in your experience has your role as a Community Nurse in Liffeside health service area changed?

- If so, why and how?

From your experience how would you describe your understanding of cultural competence or transcultural nursing?

When working with culturally diverse service users....

- How would you describe your working relationship with culturally diverse families?
- How does your own culture (values, beliefs, practices) influence your practice with clients?
- How do you deal with people whose values are significantly different to your own?

What works well for you when working with culturally diverse clients?

What obstacles or challenges occur for you when working with culturally diverse clients?

Can you tell me about your responses to these - such as?

- Interventions you made
- How you felt
- Learning from experience

How prepared do you feel professionally as a nurse in a multicultural society?

What specific supports do you have in your role when working with culturally diverse clients?

- Your skills / knowledge / experience /resources
- Management

- Colleagues / other agencies

What type, if any, training / education in cultural diversity / cultural awareness prior to or during your time working as a community nurse in Liffeside?

- How useful was this?

From your experience of working in a culturally diverse population how do you acquire transcultural health information about the health beliefs and practices of clients?

What suggestions (if any) can you make on this issue....?

Communication:

- How well do you feel able to communicate with people?
- What barriers (if any) to communication do you experience?
- What are your feelings about working with interpreters?

Within your work, what experiences of racist / discriminatory attitudes or behaviours from clients or colleagues have you encountered.....If so can you elaborate....?

- How might you consider addressing and challenging racist / discriminatory attitudes / practices?
- How do you feel the organisation (HSE) supports you in your role in this context?
- How do you feel your discipline (Nursing) supports you in this regard?

Appendix E – Practice Guidelines for Cultural Competence

Draft Template Version

HSE Logo Here

**Practice Guidelines for Cultural Competence Development for Community Nurses in Liffeside health service area Health Service Executive Dublin
Community Nursing Department
Local Health Office -**

Date Developed:		Developed By:
Date Approved:		Approved By:
Date Effective from:		Review Date:
Document No:	Edition No.	No. of Pages / Appendices

Contents:

- 1.0 Guideline Statement**
- 2.0 Scope of Guideline**
- 3.0 Guideline Purpose**
- 4.0 Definitions**
- 5.0 Conceptual / Practical Development of Cultural Competence**
- 6.0 Useful Contacts / Relevant Information**
- 7.0 Production / Consultation Trail**
- 8.0 References / Bibliography / Acknowledgments**

1.0 Guideline Statement

- 1.1** Liffeside HSE Nursing Service acknowledges that community nursing practice is guided by the principles of primary health care. The nurse, in the spirit of partnership, carries out assessment and planning of care which is equitable, accessible, culturally sensitive and which empowers the community, family and individual for self determined health care (McMurray, 1993; Papadopoulos 2006). Health promotion and education are considered at every client encounter (WHO, 1986). Principles of quality and accountability (DoHC, 2001) further enhance care.
- 1.2** The Public Health Nursing Service in Liffeside is committed to ensuring that all nursing staff adhere to best practice when working with culturally / linguistically and ethnically diverse service users in accordance with professional, legal and ethical obligations (An Bórd Altranais 2000, Council of Europe 2006, HSE 2008, WHO 2010)

2.0 Scope of Guidelines:

- 2.1** The purpose of this document is to promote best practice and the development of cultural competence for PHNs and community nursing staff working in HSE Liffeside health service area.

The aim of these guidelines is to inform and introduce nurses to the discipline of transcultural nursing and cultural competence in an effort to support nurses working with cultural / linguistic and ethnically diverse service users. The principles and practice of cultural competence are of benefit to all of society.

- 2.2.a** These guidelines do not claim to be the only substantive source of information on developing cultural competence in nursing practice in HSE Liffeside area. Nurses are encouraged, as per their professional and ethical obligations, to further source and update information and professional knowledge from reliable sources deemed appropriate for the professional standard of nursing e.g. evidence based research / established and approved specialist practices.

3.0 Guideline Purpose

- 3.1 This Guideline applies to all the nursing staff in HSE Liffeside Health Service Area. For the purpose of this document Public Health Nursing Service includes: Director of Public Health Nursing
Assistant Director of Public Health Nursing
Public Health Nurses
Registered General Nurses
Community Clinical Nurse Specialists
- 3.1.2 Under the Scope of Nursing and Midwifery Practice Framework, each nurse is accountable both legally and professionally for their own practice. (An Bord Altranais, 2000).
- 3.1.3 Maintenance of competency remains the responsibility of the practitioner.
- 3.2 For the purpose of this guideline the nurse is identified by their clinical managers as working in an environment where there is a professional clinical need for them to perform and engage effectively with all service users. Governed and guided by principles of professional nursing, nurses are expected to apply, in so far as possible, standards of care that are consensual, equitable, and accessible with the intention of ameliorating health and wellbeing of service users.

4.0 Definitions

- 4.1 Cultural Competence has been defined in nursing as:

“..the explicit use of culturally based care and health knowledge in sensitive, creative and meaningful ways to fit the general life-ways and needs of individuals or groups for beneficial and meaningful health and wellbeing of to face illness, disabilities or death”

(Leininger, 1995, P.84)

Within a broader healthcare professional and educational development context Papadopoulos (2006) has defined it as follows:

“..cultural competence is both a process and an output and results from the synthesis of knowledge and skills which we acquire during our personal and professional lives and to which we are continually adding...”

5.0 Conceptual / Practical Development of Cultural Competence (see Figure 1)

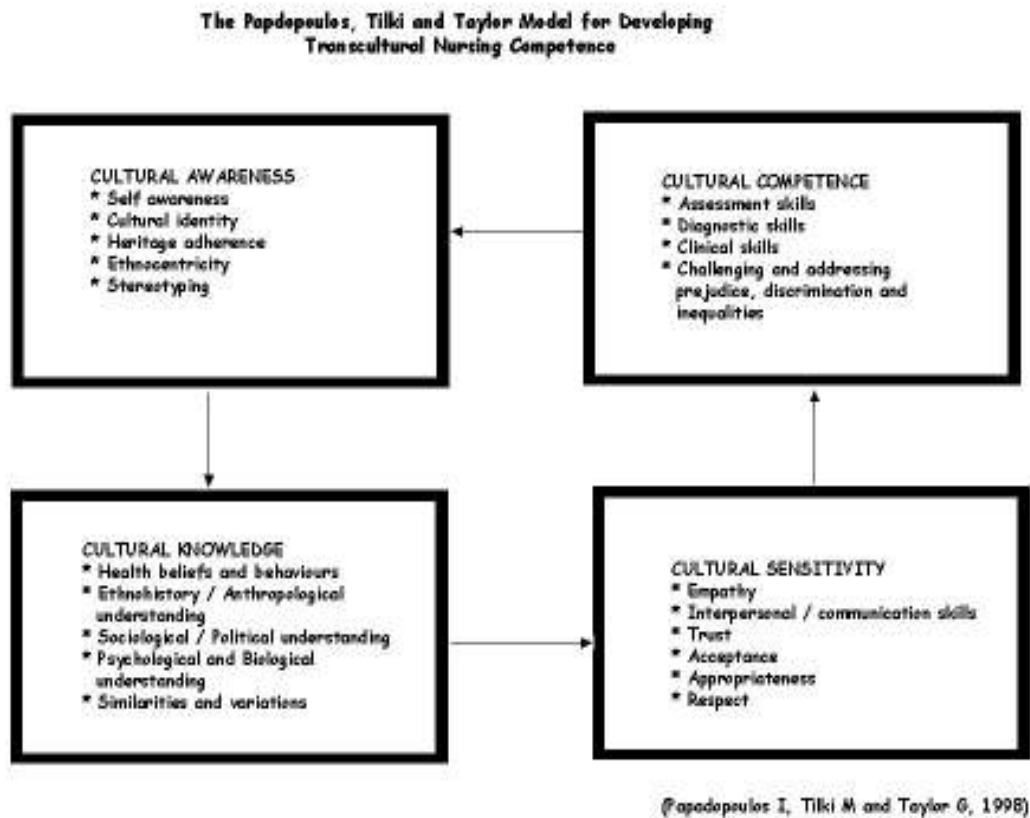


Figure 1.

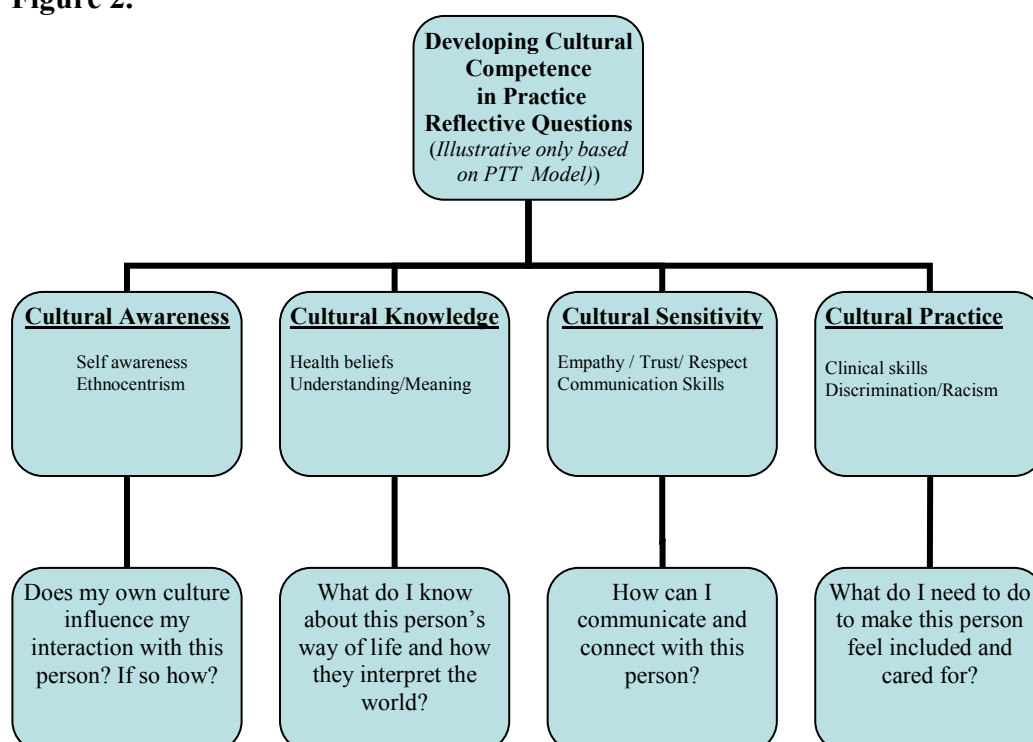
5.1 The above model i.e., Papadopoulos Tilki Taylor (PTT) Model for Developing Cultural Competence is a useful conceptual model based on theoretical principles for nurses to consider in their practice. It presents four main domains and inter-connected stages of cultural competence development:

- Cultural Awareness
- Cultural Knowledge
- Cultural Sensitivity
- Cultural Competence

There are many other models within the literature that can assist nurses in understanding and applying cultural competent nursing care (see reference / bibliography)

- 5.2 In considering applying the above PTT model (Figure 1), to aid the development of cultural competence, nurses can ask reflective questions for each stage that corresponds with their professional, ethical and legal nursing obligations. An example is illustrated in the following diagram (Figure 2)

Figure 2.



- 5.3.1 Further exploration of cultural competence theory is recommended as part of personal and professional development. This should occur within a safe learning environment with appropriate facilitation and mentoring
- 5.3.2 Transcultural nursing / cultural competence placement is also recommended for nurses with limited work-based transcultural experience. This will be facilitated and supervised by a suitably qualified nurse, as deemed appropriate by the Director of Public Health Nursing in accordance with clinical placement policy and protocol.
- 5.3.3 The Director of Public Health Nursing and practice development unit of HSE Liffeside Health Service Area will continue to provide nurses with structured learning and practice opportunities to assist in the development of cultural competence. Nurses are expected to inform nursing management and to apply for educational opportunities if deemed necessary, based on competency self assessment / or if deemed necessary by nursing management.

6.0 Useful Contacts and Relevant Information

- 6.1 The following list is a guide only and is not to be considered an exhaustive list of resources. It contains useful information and contact details of organisations relevant to supporting cultural competence in the **local HSE / Irish context**. Other information sources that may be useful in community practice e.g. migrant rights, advocacy, integration, social supports, are also included.

Health Service Executive (HSE - Social Inclusion Unit): Tel: 01-6201703

<http://www.hse.ie/eng/services/Publications/services/SocialInclusion/>

Above Webpage contains some of the following useful resources:

- Emergency Multilingual Aid and Language ID Card / Poster
- On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services.
- Lost in Translation? Good Practice Guidelines for HSE Staff in Planning, Managing and Assuring Quality Translations on Health Related Material into Other Languages
- Health Services Intercultural Guide: Responding to the Needs of Diverse religious communities and cultures in health care settings.
- National Intercultural Health Strategy 2007-2012.

HSE Specialist Psychology Service for Refugees and Asylum Seekers

St. Brendan's Hospital Grangegorman Dublin 7: Tel: 01-8693086

- Provides Specialist Clinical and Counselling Psychology
- Pre & Post Migration, Torture Survivors,
- Self-Referral / NGO / Referral / Health Professional Referral
- Waiting list in operation

HSE Refugee Health Centre Baleskin Refugee Accommodation Centre

Tel: 01-8569015/01 / 01 - 8569080

- Provision of voluntary health screening (Asylum Seekers & Refugees)
- General medical practice / Public Health medicine / Nursing & Midwifery
- Psychology / Psycho-social supports
- Primary Health Care / Community Collaborative Projects

HSE National Advocacy Unit

Quality and Patient Safety Directorate Tel: 071-9820266

Non-Governmental Organisations (NGO): Health related:

Health and Social Care (Ethnic Minority Communities):

Cáirde *Challenging Ethnic Minority Health Inequalities;*

Tel: 01-8552111

Email: info@cairde.ie

Website: www.cairde.ie:

Resources:

- Provides drop-in facility and information centre:
- Social / Integration Supports
- Capacity Building Training & Research - Reports / Publications
- Health Service Accessibility Information
- Facilitates & Accommodates Community Representative Groups e.g., Akidwa African Women's Network, Irish Kurdish Society, Congolese Irish Partnership

Open Heart House: HIV Membership Organisation

Tel: 01-8305000

Email: info@openhearthouse.ie

Website: www.openhearthouse.ie

Resources:

- Peer support / hospitality
- Capacity building / leadership/advocacy
- Training and education
- Personal Growth & Wellness Programme

Irish Transcultural Nurses Network (TNN)

Tel: 087-9120382

Email: transculturalnurses@eircom.net

Website: www.tnn.ie

Resources:

- On-line resource for nurses to source information on transcultural nursing and cultural competence. Currently a limited resource but contains links to more established and specialist centres of excellence including Research Centre for Transcultural Studies in Health Middlesex University U.K. and The European Transcultural Nursing Association (ETNA)
<http://etna.middlesex.wikispaces.net>

Cultural Competence in Health Care (International)

- www.hsph.harvard.edu
- www.health.viv.gov.au
- www.nccc.gerogetown.edu/
- www.rcn.org.uk/development/learning/transcultural_health/
- www.xculture.org
- <http://erc.msh.org/aapi/tt11.html> (Klienman Explanatory Model)
- <http://www.transculturalcare.net/>
- http://www.cno.org.docs/prac/41040_CulturallySens.pdf
- http://www.who.int/social_determinants/thecommission/finalreport/en/index.html

Cultural Health / Social Care Resources Relevant to Community Nursing (Irish Context):

- *'Key Contact: Guidelines on: Reproductive Health Information for Migrant Women; Pregnancy Prevention, Crisis Pregnancy Options, Related Health Matters'*. **By Treoir and Crisis Pregnancy Agency (2005)**
(Available in English, Arabic, Chinese, French, Polish, Romanian, Russian)
Available @ www.crisispregnancy.ie/publications
- *'Female Genital Mutilation (FGM) Information for Healthcare Professionals Working in Ireland'* (2008) By Royal College of Surgeons of Ireland / AkiDwA: Available @ <http://epubs.rcsi.ie/obsgynrep/1/>
- *'GLOBE All Ireland Programme for Immigrant Parents'* (2008)
(Toolkit / Information Resource & DVD) Available @ <http://www.culturewise.ie/resources-globe.html>
(Available in English, Arabic, Chinese, French, Latvian, Polish, Somali, Urdu, Portuguese and Russian)
- *Child Safety: Inside and Outside the Home (DVD)*
A Guide for Parents, Guardians & Children
(Available in English, Gaeilge, Arabic, Russian, French, Polish, Chinese) Available from: HSE Health Promotion
http://www.hse.ie/eng/services/Publications/services/Children/Child_Safety_Inside_and_Outside_the_Home.html
- *Prepare Your Child for Hospital* Booklet for Parents & Families by Children in Hospital Ireland.
Available @ <http://www.childreninhospital.ie/publications>
(Available in Irish, English, Arabic, Chinese, Filipino, Russian, Polish, French, Romanian, Spanish, Portuguese)
- *Living with HIV in Ireland: A Self Help Guide* (2009)
Dublin Aids Alliance
<http://www.dublinaidsalliance.ie> (multilingual website)
- *Key Principles for Working with LGBT Asylum Seekers and Refugees*
Information and Resource Pack: BeLonG To (2012)
Available from: www.belongto.org
- SPIRASI Cultural Profiles (on-line resource – health related issues)
Available @ <http://cultural.profiles.spirasi.ie/>

Non-Governmental Organisations (NGO) Ethnic Minority Social Integration: Information / Support / Advocacy.

- Crosscare - Crosscare Blanchardstown Liffeside health service area
Tel: 01-8219892
Email: jmartin@crosscare.ie
Website: www.crosscare.ie
- Crosscare Refugee Project
Tel: 01-8683358 / 59
Email: breegekeenan@crosscare.ie
- Blanchardstown Area Partnership
Tel: 01-01-8209550
Email: info@bap.ie
Website: www.bap.ie
- New Communities Partnership Ireland
Tel: 01-6713639
Website: www.newcommunities.ie
- Immigrant Council of Ireland
Tel: 01-6740202
Email: admin@immigrantcouncil.ie
Website: www.immigrantcouncil.ie
- Migrant Rights Centre Ireland
Tel: 01-8897570
Email: info@mrci.ie
Website: www.mrci.ie
- Irish Refugee Council
Tel: 01-7645854
Email: info@refugeecouncil.ie
Website: www.irishrefugeecouncil.ie
- The Integration Centre
Tel: 01-6453070
Email: info@integrationcentre.ie
Website: www.theintegrationcenter.ie

Useful Websites:

Government Sources: re: Information / Advice / Statistics

- www.orac.ie (Office of Refugee Application Commissioner)
- www.inis.gov.ie (Irish Naturalisation and Immigration Service)
- www.ria.gov.ie (Reception and Integration Agency)
- www.integration.ie (Office for the Promotion of Migrant Integration)

International Agencies: re: Voluntary Repatriation / Support / Advice

- www.unhcr.ie (United Nations Higher Commission - Dublin Office)
- www.iomdublin.org (International Organisation for Migration Dublin Office)

7.0 Production Consultation Trail / Contact Details

7.1 This document was produced in keeping with the approved template for Guideline Production for HSE Liffeside Health Service Area Community Nursing Services. It is subject to peer review by the Practice Development Unit, Director of Public Health Nursing (DPHN) and other relevant stakeholders as deemed appropriate by DPHN e.g. service user representatives.

Contact Details:

Ms. Marianne Healy
Director of Public Health Nursing
LHO HSE Dublin
Primary Community & Continuing Care
Nexus Building Unit 4&5
Blanchardstown Corporate Park
Liffeside health service area
Tel: 01-8975110

Contact Details:

P.J. Boyle
Clinical Nurse Specialist
(Asylum Seekers Health Assessment)
HSE Refugee Health Screening Clinic
Balseskin Refugee Centre
St. Margaret's Rd.
Finglas
Liffeside health service area
Tel: 01-8569015 / 8569080

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Appendix F – Transcultural Clinical Placement (Sample)

Nurse Placement Schedule in HSE Refugee Health Centre (Balseskin) **Transcultural Nursing & Cultural Competence** **Post-Graduate**

Day	Morning	Afternoon
Monday	<ul style="list-style-type: none"> • Meet HSE clinic staff • Tour of accommodation • Tour of clinic • Observing Health screening 	<ul style="list-style-type: none"> • Information session • Sit-in with nurse-midwife / CNS • Ethical issues • Questions & Answers
Tuesday	<ul style="list-style-type: none"> • Observing Health screening • Review Case notes • Psychology Clinic 	<ul style="list-style-type: none"> • Sit-in with AMO –Public Health Doctor • Sit-in with GP
Wednesday	<ul style="list-style-type: none"> • Children's Issues • Pre-School visit • Play therapy 	<ul style="list-style-type: none"> • Case notes (children) • Explain Partnership (NGO / Voluntary sector)
Thursday	<ul style="list-style-type: none"> • Sit-in with CNS • Intercultural Health • TCN/Cultural Competence • Interagency Collaborative Working 	<ul style="list-style-type: none"> • HSE Primary care • Site Visit (other hostel) • NGO Sector Visit • Peer Led Info / Migration
Friday	<ul style="list-style-type: none"> • Observe Health Screening • Review TCN & Social Inclusion in HSE Primary Care 	<ul style="list-style-type: none"> • Reading time for Transcultural Nursing • Research • Questions & Answers
Signed:	School:	Approved:
Date:	Programme:	Review:

Appendix G – Project Meeting Agenda



Babeskin Health Screening Centre
Babeskin Reception Centre
St. Margarets Road
Ringside
Dublin 11

Tel: (01) 856 9015
Fax: (01) 856 9022

Project Meeting with:

DProf Candidate P.J. Boyle – CNS (asylum Seekers Health)
Doctorate in Professional Studies (Transcultural Health) Work Based Learning Unit - School
of Health & Social Sciences
Middlesex University London

Venue: Babeskin Health Centre - Wednesday 27th July 2011 - 14.00hrs

Present:

- Ms. Marianne Healy – (Line Manager) Director of Public Health Nursing HSE North West Dublin.
- Dr. Mary Tilki (Academic Advisor) School of Health Social Science Middlesex University London
- Dr. Teresa Nyland (Project Advisor) - Acting Head – Community Development / Primary Care HSE North West Dublin

Provisional Agenda:

Approx Time Frame: 2 hours

1. Introductions & acknowledgements (10 mins)
2. Summary outline of DProf Programme course work completed to date
Handout - (Matrix chart - Modules, credits, RALS, Results) (15 mins)
3. Outline of Final Project (PTT Panel Presentation – subsequent amendments)
(10 mins)
4. Current activities / work to do. (Project template (assignment) – module
handbook) (15mins)
5. Discussion / advise / questions (40 mins)
6. Plan - study time table / A/L time / provisional submission dates / funding
(15 mins)
7. AOB (15 mins)

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